

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 3 9 7 6 | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS EUGENE AHERN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/25/82 | | | | 2b. HOUR 8 37 PM | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR FEB 10, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 82 | | IF UNDER 24 HRS. HOURS MIN. 82 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREIGN SERVICE | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. COMMERCIAL | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 575 THAYER AVENUE | | DEPT. 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-4772 | | 17. INFORMANT NANCY PERRY | | ADDRESS 3701 CHATHAM ROAD | | CITY OR TOWN ELLCOTT CITY, MD. | | STATE 21043 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic thoracic aortic aneurysm 4412 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a chronic bronchitis & pulmonary emphysema | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-25-1982 , to 9-25-1982 , that (I) (last saw the deceased alive on 9-25-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "I" did not view the body after death, so state.) | | | | | | | | | | | | | |
| 22b. SIGNATURE George Sengstack | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-26-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE SENGSTACK | | | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

Cleared by Dr. Rogers (Cathy, nurse, etc.)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|------------------|--|--|--|--|---|---------------|--|--|---|--|--|---|---|--|--|--|--|---|--|--|---------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Richard | | | MIDDLE H. | | | LAST Allen | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 09 | | | DAY 03 | | | YEAR 1982 | | | 2b. HOUR 5:30 AM | | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 05 24 31 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 09 03 82 | | | 2d. HOUR 5:30 AM | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Sil. Spg. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp. | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Spec. Officer (Ret.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY Army | | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 17 Featherwood Ct 43 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Allen | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Weeks | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Army | | | | 16b. SOCIAL SECURITY NO. 040-24-1165 | | | | 17. INFORMANT ADDRESS Wilma Jean Allen 17 Featherwood Ct. S.S. | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> 4291 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Myocardial Dis 1 yr</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>None</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John P. Rogers</u> | | | | | | TITLE (SPECIFY) M.D. <u>BCR</u> | | | | | | MEDICAL EXAMINER | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE 9/8/82 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | | | | | | | | | | | |
| 23d. LOCATION (CITY OR TOWN) Arlington | | | | | | COUNTY Va. | | | | | | STATE | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Service INC 7400 Ga. Ave., N.W., DC | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | | | | | | | | | |

RECEIVED
JAN 10 1964
FBI
COMMUNICATIONS SECTION

TO DIRECTOR, FBI
FROM SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a teletype message with various headers and body text.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, all medical personnel must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|
| 1. STATE REGISTRAR | | | | | 8 2 2 3 9 7 8 | | | | |
| FOR 1. STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Anne Anne Sisson Anderson Anderson | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 06 82 | | | 2b. HOUR 10 ²⁵ A.M. | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR October 17, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Surveyor | | 12b. KIND OF BUSINESS OR INDUSTRY Information | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13e. STREET ADDRESS 4521 East West Highway (20014) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fred J. Sisson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace McCormick | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT Elbert Sisson | | Post Office Box 27 Bryans Road, MD 20616 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Branchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year 11 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ Asthmatic Bronchitis | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6, 1982, to 7/6, 1982, that (I) (we) last saw the deceased alive on 9/6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joel Schulman | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schulman | | 22e. ADDRESS 9410 Old Georgetown Rd Bethesda | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE September 7, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |
| Old Alexander Ferry Road, Clinton, Maryland | | | | | | | | | |

BP

WABT-TV

September 7, 1904 Lee's Laboratory

NOTES:

8 2 2 3 9 7 9
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on Item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | YEAR | | 2b. HOUR | |
| Mary | | L. | | Anonsen | | 9-26-1982 | | 11 | | 15 | | A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | June 23 1901 | | 81 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Takoma Park | | WASHINGTON ADVENTIST | | Housewife | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | PG-AA | | Glen Burnie | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1011 Pinetop Drive | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Charles | | | | Sarah | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 220-48-3966 | | | | Dorothy Hodgdon, Daughter Same as Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4140 IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | | | approx 1 yr. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| Hemiparesis | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | 9/24 82 | | 9/26 82 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 82, to 9/26 19 82, that (I) (we) last saw the deceased alive on 9/25 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| Antonio G. Uy | | M.D. | | | | 9/26/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| Antonio G. Uy | | 831 Union Blvd E # 28 S.S. Md 20903 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Burial | | 9-29-82 | | Cedar Hill Cem. | | Suitland, P.G. Parish | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | | | | | | | |
| Robt E Wilhelm | | 4308 Suitland Rd., Suitland, Md. | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Funeral Home | | | | | | | | | | | | | |

Washington

Washington

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 9 8 0

REG. NO.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Clea Ruth Antor | | | MONTH DAY YEAR 09 21 82 | | | 1027 A.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Female | White | MONTH DAY YEAR 09 02 20 | 63 YRS | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Michigan | United States | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | Shady Grove Adventist Hospital | | Housewife | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD | | | Frederick | | | MT. AIRY | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Frank Leo Bachteller | | | FIRST MIDDLE LAST Verna Ethel Willsie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 364263553 | | | 3100 Cantee Lane Frederick Antor Mt. Airy, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) pancreatic carcinoma | | | | | | | | 5 mo. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/20 to 9/21, 1982, that (I) (we) last saw the deceased alive on 9/20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE John R. Melnick MD | | | | | | DEGREE | | 22c. DATE SIGNED |
| | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 9/21/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick | | | | | | 22e. ADDRESS 16220 Frederick Road - Crofton, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | 9/25/82 | | Oak Grove Cem. | | Crofton Twp. Newaygo Mich. | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | |
| G. Douglas Stauffer, Frederick, Md. | | | | | | 1621 Opossumtown Pike SEP 29 1982 John J. Connel | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified and checked.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|---------------------------------------|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DOROTHY PENNY ATKINS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20 1982 | | | 2b. HOUR 4:50 PM | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 4 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA | | | | | 13b. COUNTY ARLINGTON | | 13c. CITY OR TOWN ARLINGTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK PENNY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 130-24-4903 | | 17. INFORMANT ADDRESS BARRY ATKINS, 1600 S. EADS STREET, ARLINGTON, VA 22202 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4413 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Abdominal Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 2, 1982 , to SEPTEMBER 20, 1982 , that (I) (we) last saw the deceased alive on SEPTEMBER 20, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 22 Sept 82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. DAVIS, LCDR, MC, USNR | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 22 SEPT 82 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. CHAMBERS COMPANY, INC. 8653 GEORGIA AVENUE SILVER SPRING, MD | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

Blank lined paper with faint horizontal lines and two binder holes on the right side.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

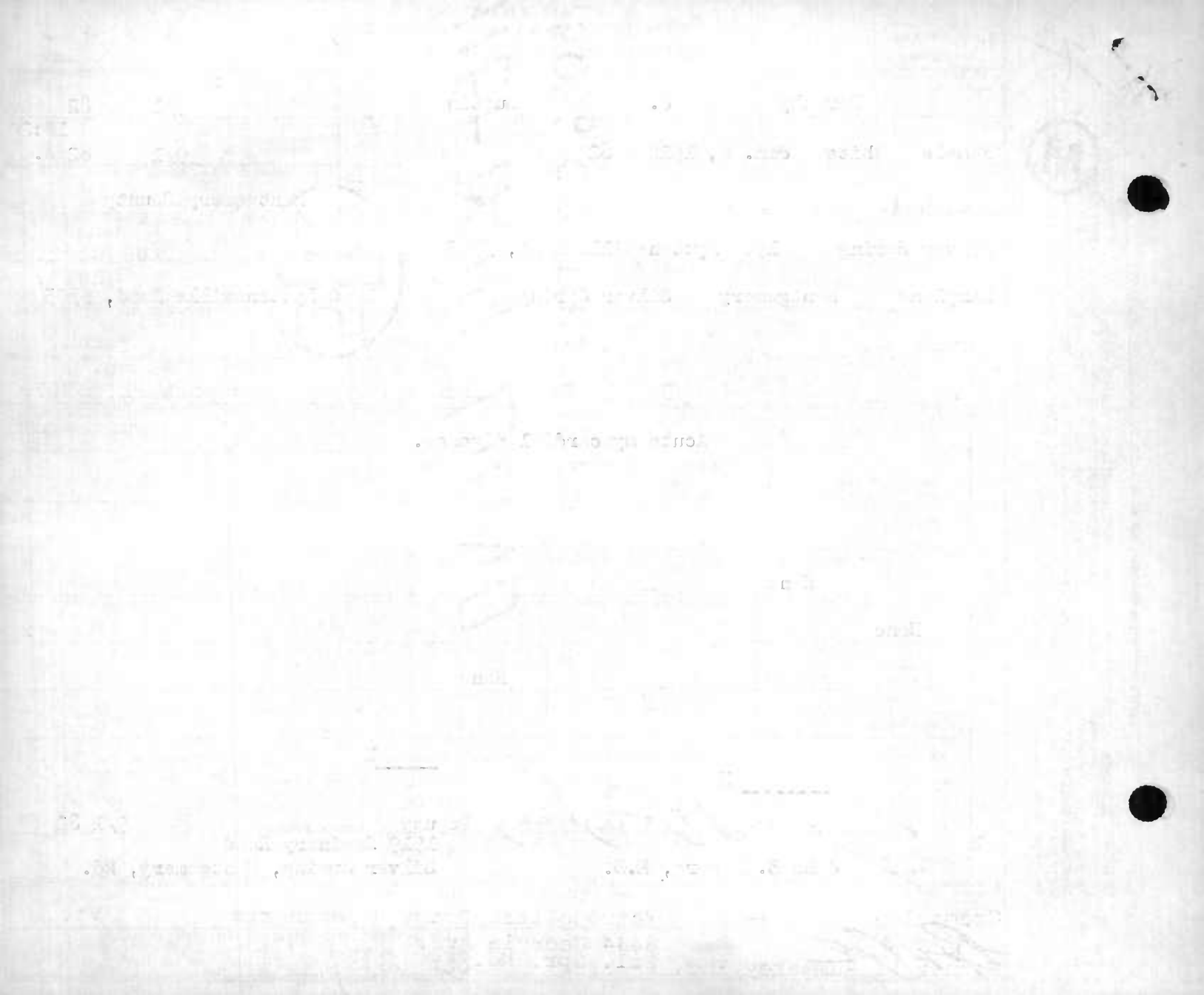
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy J. Austin | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/1 19 82 | | | 2b. HOUR 10:20 A. M. | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1920 | 6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/1 19 82 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY? America | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1900 Lyttonsville Road, #503 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY US Govt. |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1900 Lyttonsville Road, #503 20907 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Erving G. Austin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Murphy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 388 16 4499 | | 17. INFORMANT 3407 ¹⁵ Rose St. Mitzi T Bishop Sarasota Fl. 33579 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Rogers</i> | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 9/1/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-4-82 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem: | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va. | | |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i> | | ADDRESS 8434 Georgia Ave. Sil. Spr. Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Comer</i> | | |

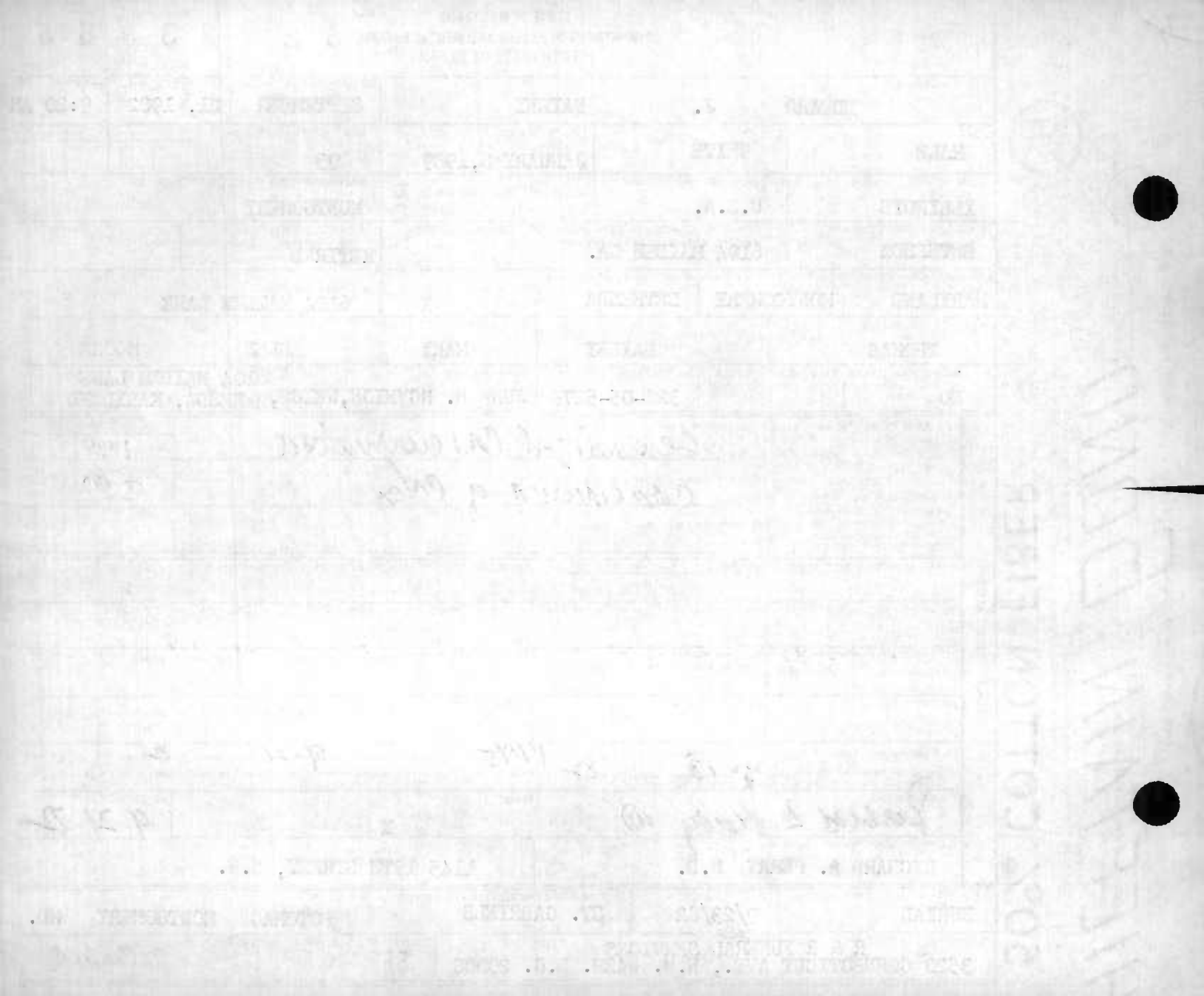


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 3 9 8 3 | | | | | |
|---|--|--|--|--|---|--|--|--|---|--|------------------|--|-----------------------------------|-----------------|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| FIRST MIDDLE LAST EDWARD J. BAILEY | | | | | | | | | | MONTH DAY YEAR SEPTEMBER 21, 1982 | | | | 9:20 AM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | | WHITE | | | MONTH DAY YEAR JANUARY 8, 1989 | | | 93 YRS. | | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| ILLINOIS | | | U.S.A. | | | | | | MONTGOMERY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | | 6104 MAIDEN LA. | | | | | | | RETIRED | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 6104 MAIDEN LANE | | | | |
| MARYLAND | | | MONTGOMERY | | | BETHESDA | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| FIRST MIDDLE LAST THOMAS BAILEY | | | | | FIRST MIDDLE LAST MARY ELLEN MOORE | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | | | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | | | 328-05-5278 | | | | | JUNE B. MCVEIGH, NEICE, BETHESDA, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) Generalized Carcinomatosis | | | | | | | | | | 1 mo. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon | | | | | | | | | | 3 mo. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION | | | | | |
| | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1985, 19, to 1982, 9-21, that (I) (we) lost the deceased alive on 9-18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Richard A. Perry M.D. | | | | | | | | | | | | 9-21-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | |
| RICHARD B. PERRY M.D. | | | | | | | | | | 1145 19TH STREET, N.W. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| BURIAL | | | | | 9/23/82 | | | | | ST. GABRIELS | | | | | |
| 23d. LOCATION | | | | | 23e. DATE REC'D. BY REGISTRAR | | | | | 23f. REGISTRAR'S SIGNATURE | | | | | |
| CITY OR TOWN COUNTY STATE POTOMAC MONTGOMERY MD. | | | | | SEP 24 1982 | | | | | John J. Connel | | | | | |
| 24. FUNERAL DIRECTOR NAME R & R FUNERAL SERVICES 3520 CONNECTICUT AVE., N.W. WASH. D.C. 20008 | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 3 9 8 4 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN MELVIN FREDERICK BARGER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-10-82 | | 2b. HOUR 8:10a M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 1, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. America | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | 12a. USUAL OCCUPATION (KIND OF WORK FOR MOST OF WORKING LIFE) Office Manager | | 12b. USUAL PLACE OF WORK Washington D.C. or Kingsville, Inc. | |
| 13a. STATE Md. 20783 | | | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Hyattsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Frederick Barger | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nillie M. Whipp | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (LAST FOUR DIGITS OR DATES) WW 11 | | 17. INFORMANT ADDRESS Inez W. Barger Same as #13 (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 4100 DUE TO, OR AS, A CONSEQUENCE OF (b) <u>Recent myocardial infarction</u> DUE TO, OR AS, A CONSEQUENCE OF (c) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>non-applicable</u> | | | | | | | |
| 19a. DATE OF OPERATION 9-9-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>coronary artery disease</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>sept. 1</u> 19 <u>82</u> , to <u>sept. 10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>sept. 10</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>John J. Conner</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ki-choon Kim, M.D. | | | | 22e. ADDRESS 7600 Carroll Ave. Takoma Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | 23b. DATE 9/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION Brentwood Prince Georges County Maryland | |
| 24. FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 9 8 5

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MIDDLE LAST | | SEPT 12 82 | | 2:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| M | | WHITE | | MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Washington, D.C. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Silver Spring | | Holy Cross Hosp. | | Public Relations | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | |
| MD | | MONTGOMERY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ABRAHAM BARITZ | | SARAH SHAPIRO | | Pvt. Industry | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| YES | | WW 11 | | STANLEY BARITZ; 6630 Paxton Rd; Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | |
| 4100 | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) CORONARY ARTERY DISEASE | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (CITY OR TOWN, COUNTY, STATE) | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964, 19, to Sept 12, 1982, that (I) (we) lost | | | | | |
| saw the deceased alive on Sept 12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| ROBERT KRATTER | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 9/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| ROBERT KRATTER | | 8630 FENTON RD. SILVER SPRING MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/14/82 | | KING DAVID MEMORIAL GDN.; FALLS CHURCH; FAIRFAX; VA. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | SEP 16 1982 | | John J. Conner | |
| 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | |

BP

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 9 8 6

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| JAMES | | ALBERT | | BARNES | | SEPTEMBER 1, 1982 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | APRIL 2, 1930 | | 52 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| ILLINOIS | | U.S.A. | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE AND FIRST ONE ONLY) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| KENSINGTON | | 5016 DRUID DRIVE | | CONTRACT DRIVER | | BYLINE DELIVERY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | MONTGOMERY | | KENSINGTON | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | 13f. CITY OR TOWN | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 5016 DRUID DRIVE | | 20895 | |
| CLARENCE | | BARNES | | MILDRED | | MORGAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 357-24-5160 | | BLYTHE BARNES, WIFE, | | 5016 DRUID DRIVE KENSINGTON, MD. 20895 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 1533 DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma sigmoid colon</u> Approximate interval between onset and death <u>3 1/2 months</u> <u>9 months</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 82</u> to <u>Sept 1, 82</u> saw the deceased alive on <u>August 24, 82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. ADDRESS | | 22d. DATE SIGNED | |
| WILFRED R. EHRMANTRAUT MD | | WILFRED R. EHRMANTRAUT | | 1125 ROCKVILLE CKE ROCKVILLE MD | | 9/1/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| CREMATION | | 9/2/82 | | CEDAR HILL CREMATORY | | SUITLAND PG. MD | |
| 24. FUNERAL DIRECTOR NAME R & R CREMATION SERVICES 3520 CONN. AVE., N.W. WASH., D.C. 20008 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | SEP 7 1982 | | John J. Carver | |

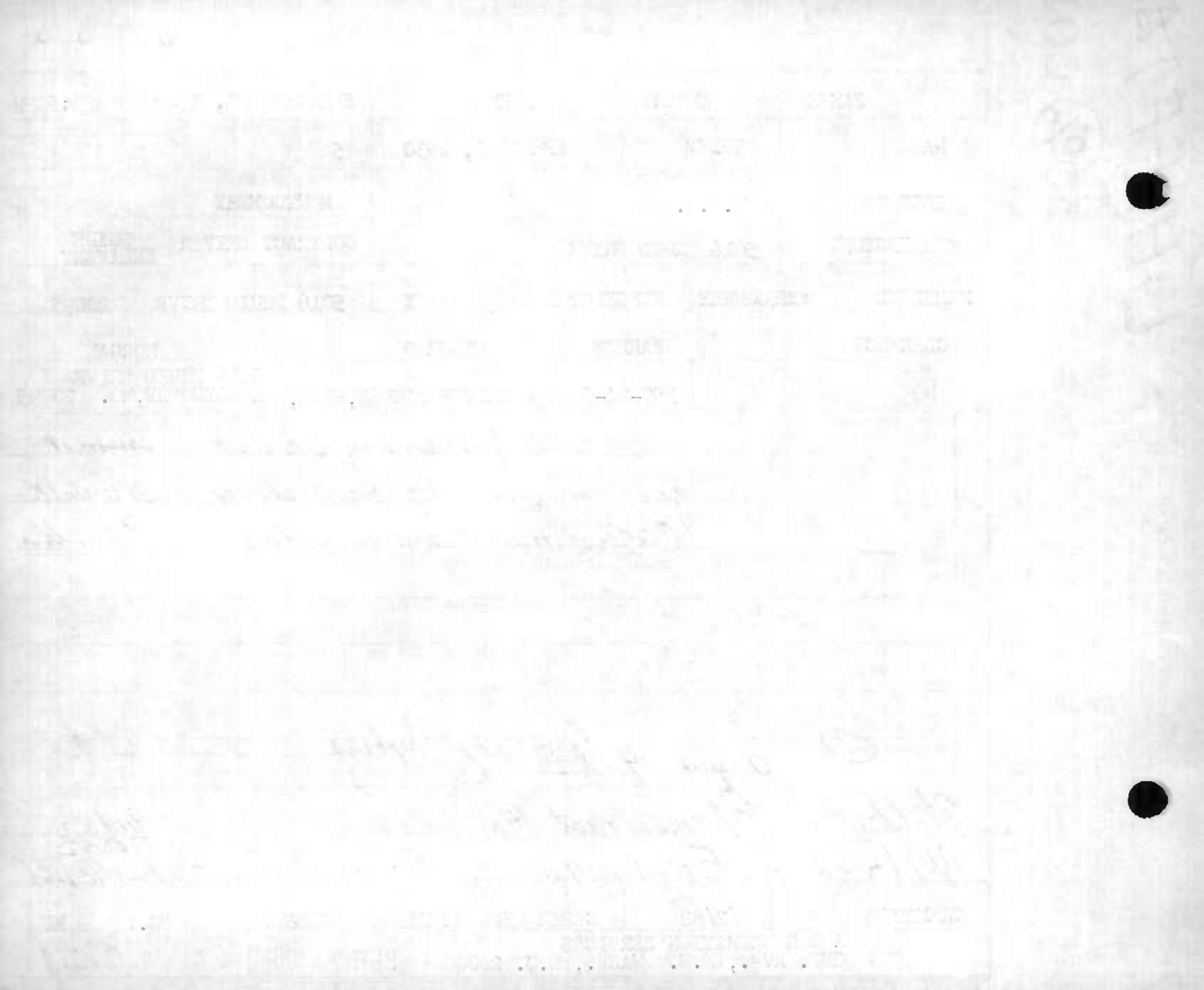
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| 1. FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 3 9 8 7 | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| GRACE L. BASILIO | | | | 9 1 82 | | | | 14 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| F | | CAUC. | | 11 27 09 | | 72 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maine | | Amer | | | | Montgomery County | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Washington Adventist Hospital | | | | Waitress | | Restaurant | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | Pr George | | Forestville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7108 Beltz Drive | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William H Ebert | | | | Frances Edwards | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 578 16 7771 | | Blanche E Thompson Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>STROKE (CVA)</u> | | | | | | | | | | DAYS | |
| 2396 DUE TO, OR AS A CONSEQUENCE OF (b) <u>THIRD VENTRICLE WITH</u> | | | | | | | | | | DAYS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAROTIDOPHARYNGEAL OF</u> | | | | | | | | | | WEEKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <u>Renal failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| August 15, 1982 | | THIRD VENTRICLE TUMOR | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> 19 <u>82</u> to <u>9/1</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>8/31</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>Kenneth Cruze MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | <u>9/1/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Kenneth Cruze | | | | 831 University Blvd Silver Spring Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Cremation | | 4 Sept 82 | | Cedar Hill Cemetery | | Suitland | | Maryland | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | 25. DATE REC'D. BY REGISTRAR | | | | REGISTRAR'S SIGNATURE | | | |
| Robert E Wilhelm | | | | SEP 8 1982 | | | | <u>John J. Conner</u> | | | |
| Suitland Maryland | | | | | | | | | | | |

MEDICAL CERTIFICATION

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9

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 9 8 8

REG. NO.

1. FOR
STATE
REGISTRAR

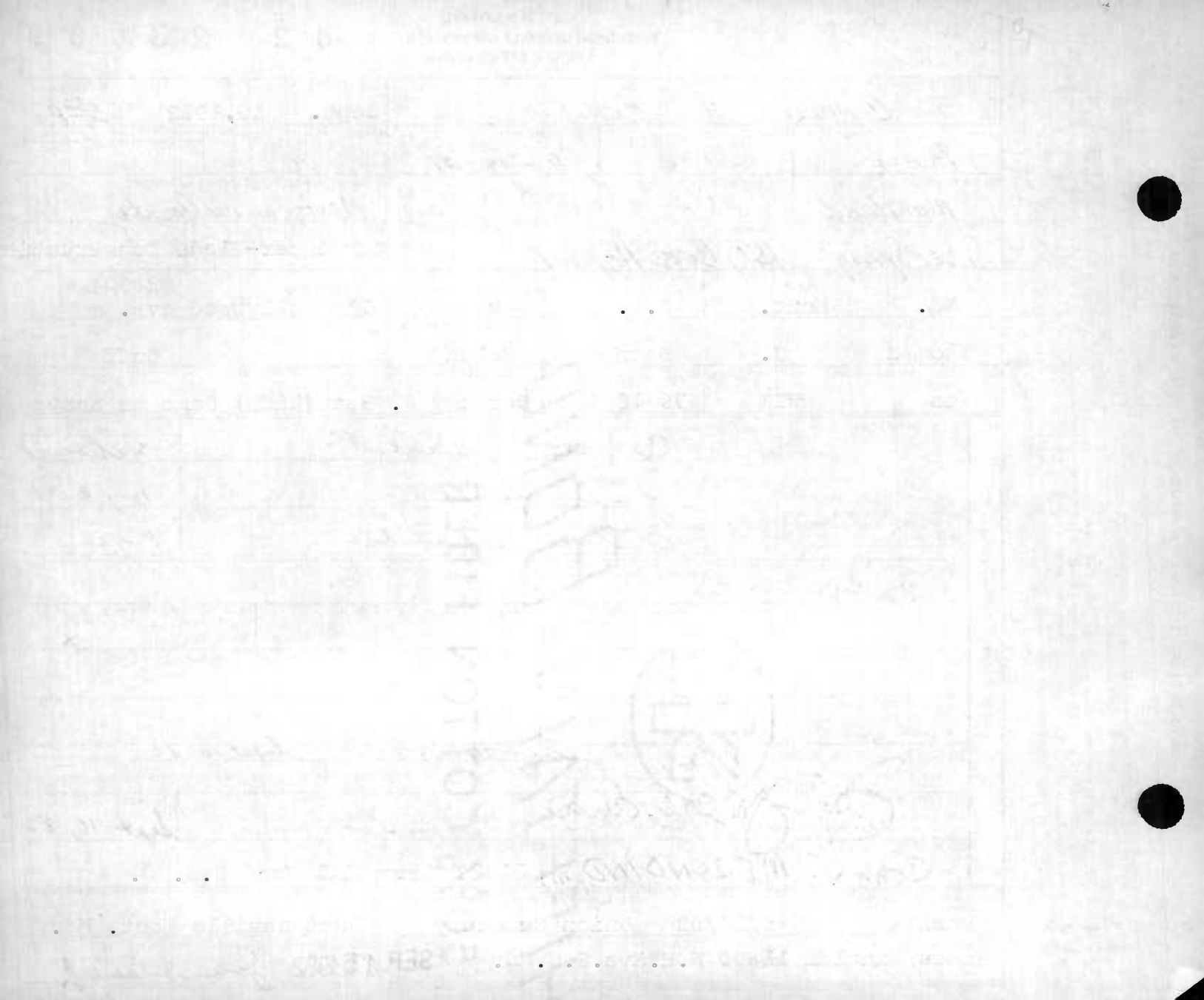
| | | | | | | | |
|--|--|--|---|---|--------------------------|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MITCH NMI BAUER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16 1982 | | 2b. HOUR 9:30a | | |
| 3 SEX FEMALE | | 4 RACE JAPANESE | | 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 23 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAPAN | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, NMMC | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE MAINE | | 13b. COUNTY AROOSTOK | | 13c. CITY OR TOWN PRESQUE ISLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 51 SUNSET LOOP | | 14. FATHER'S NAME FIRST MIDDLE LAST DENKICHI NAKAZATO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATSU OYAKAWA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT JAMES F. BAUER II | | ADDRESS 51 SUNSET LOOP PRESQUE ISLE, ME 04769 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) POORLY DIFFERENTIATED LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 SEPTEMBER 19 82 , to 16 SEPTEMBER 19 82 , that (I) (we) last saw the deceased alive on 16 SEPTEMBER 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Michael S. Miller</i> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 16 SEP 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL S. MILLER, LT, MC, USNR | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MARYLAND 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SP) CREMATION | | 23b. DATE 19 SEP 82 | | 23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY | | 23d. LOCATION WASHINGTON DC COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <i>Wayne F. Felt</i> ADDRESS Demaine Funeral Homes, Inc., Alex., Va. 22314 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 REGISTRAR'S SIGNATURE <i>John J. Conner</i> | | | |



X

and

Richard M. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 3 9 9 0 | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|-------|--|------|--|----------|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Eleanor | | R | | Beu | | | | 9 | | 10 | | 82 | | 11 | | 05 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Female | | CAUCASIAN | | OCT 8, 1916 | | 65 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| WASHINGTON, D.C. | | U.S.A. | | | | Montgomery | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Bethesda | | Suburban Hospital | | HOUSEWIFE | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | MONTGOMERY | | DERWOOD | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17777 BOWIE MILL ROAD | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| HUBERT | | REILEY | | ELIZABETH | | HUBER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 577-05-9645 | | RODERICK T. BELL, SR. | | SAME AS 13 HUSBAND | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> | | | | | | | | | | hours | | | | | | | |
| 3989 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial Arrhythmia</u> | | | | | | | | | | year | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatic Heart Disease</u> | | | | | | | | | | year | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 1/80 | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/5</u> , 19 <u>82</u> , to <u>9/10</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| <u>Joel Schelman</u> | | | | | | 9/10/82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Joel Schelman | | 9410 Old Georgetown Rd Bethesda Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| BURIAL | | 9/14/82 | | GATE OF HEAVEN | | SILVER SPRING | | MONT | | MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| FRANCIS J. COLLINS | | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | SEP 16 1982 | | <u>Francis J. Collins</u> | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

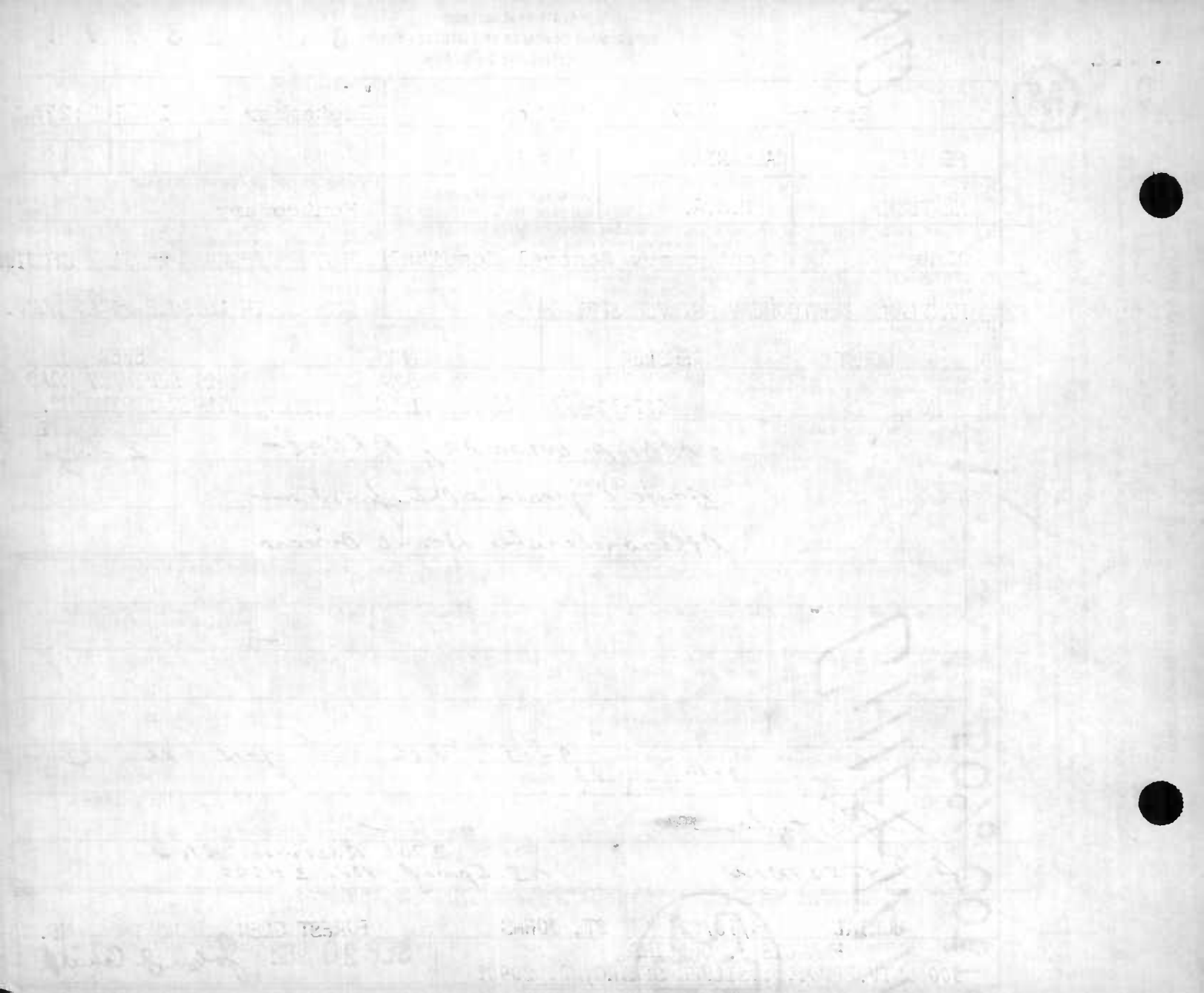
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 3 | 9 | 9 | 1 | | |
|---|--|--|--|--|---|---|--|--|--|--|---|---|--|--------------------|---|---|--|--|
| 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther MARY Bishop | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 15, 1982 | | | | 2b. HOUR 9:27AM | | | | |
| 3. SEX FEMALE | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH NOV 17, 1896 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHOTOGRAPHER | | | 12b. KIND OF BUSINESS OR INDUSTRY RENSLER STUDIO. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3429 SOUTH LEISURE WORLD BLVD. 20906 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AUGUST RENSER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MEYER | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | | 16b. SOCIAL SECURITY NO. 287-10-8978 | | 17. INFORMANT SON ADDRESS 2421 SEMINARY ROAD EDWARD RENSER BISHOP SILVER SPRING, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>82</u> , to <u>9-15</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>9-14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>A. Rotstein</u> | | | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ROTSTEIN | | | | | | | | | | 22e. ADDRESS 3701 Rosemar Blvd S. Spring, Md. 20906. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE FOREST GLEN MONT MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | 25a. DATE OF DEATH SEP 20, 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 3 9 9 2 | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Alexander Maxwell Blackburn | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 1, 1982 | | | | 2b. HOUR 8:30 PM | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 30 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Newspaperman | | 12b. KIND OF BUSINESS OR INDUSTRY Publishing | | | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Potomac | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Maxwell Blackburn | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Jouett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. 138 09 0377 | | 17. INFORMANT ADDRESS Alexander M. Blackburn (Son) see # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 mo 6 mo | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Anemia</u> <u>liver disease</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Aug</u> , 19 <u>82</u> , to <u>Sept 1</u> , 19 <u>82</u> , that (I) <u>we</u> lost saw the deceased alive on <u>Sept 1</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did not</u> view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John S. Saia MD</u> | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia, MD | | | | | | 22e. ADDRESS 809 Viers Mill Road, Rockville, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u> | | | | | |
| P.A. Rockville, Maryland | | | | | | | | | | | | | |

BP.

DECLASSIFIED

NOV 10 1962

Continued

Source: H. Lawrence, former U.S.

R. Lockville, Memphis

Investigation for story, "Alexander's Friends"

John A. - 1 - The 1961 Post, "Lockville, Tennesse"

Handwritten notes:
Alexander, H. Lockville, Tennesse
1961 Post, "Lockville, Tennesse"

Handwritten notes:
Alexander, H. Lockville, Tennesse
1961 Post, "Lockville, Tennesse"

Handwritten notes:
Alexander, H. Lockville, Tennesse
1961 Post, "Lockville, Tennesse"

1960 09 077 Alexander, H. Lockville (son) age 10

Alexander, H. Lockville, Tennesse

1960 09 077 Alexander, H. Lockville (son) age 10

Alexander, H. Lockville, Tennesse

Continued

Alexander, H. Lockville, Tennesse

Alexander, H. Lockville, Tennesse

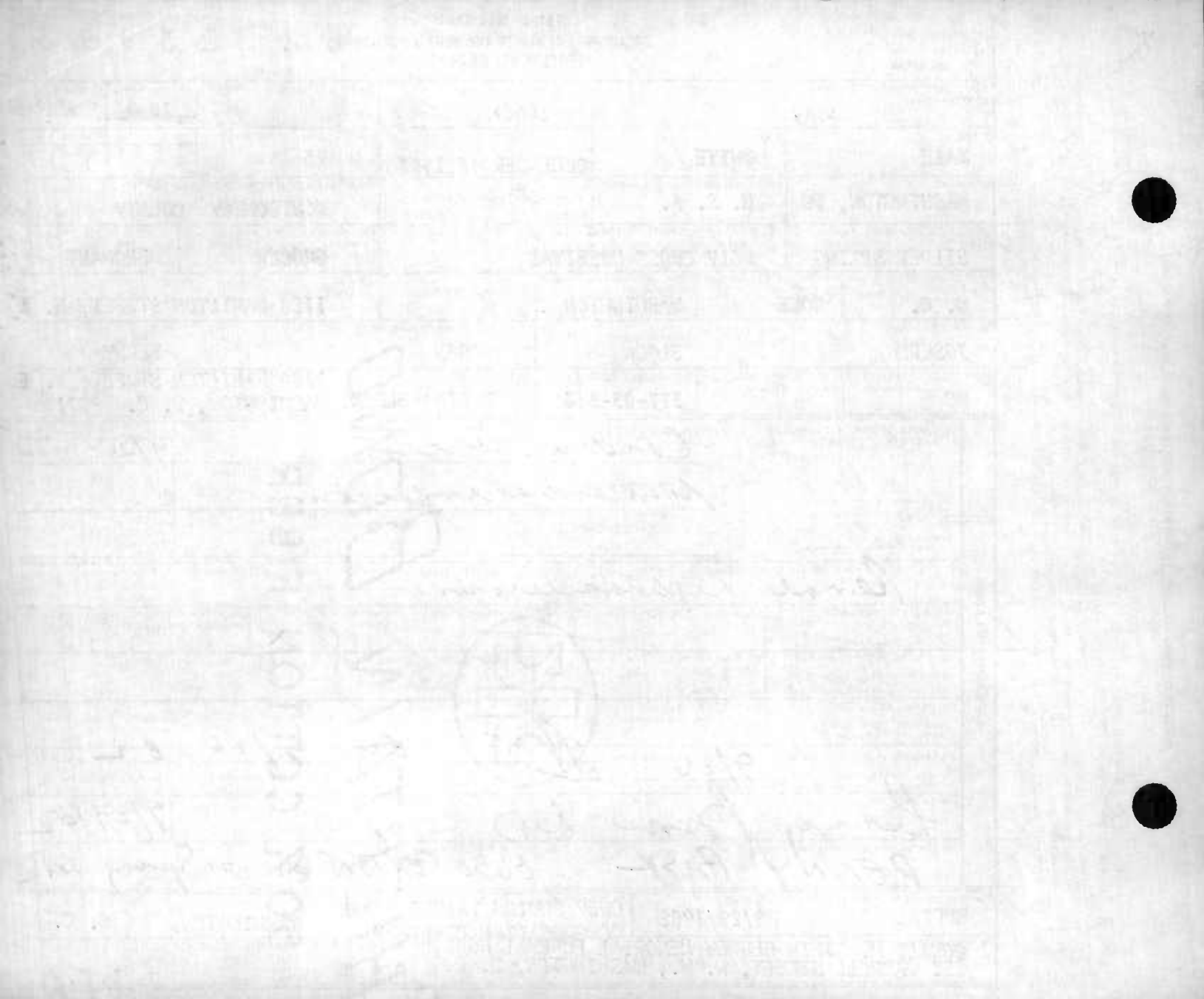
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| <div style="text-align: right;">8 2 2 3 9 9 3</div> <div style="text-align: center;"> CERTIFICATE OF DEATH REG. NO. </div> | | | | | | | | | |
| 1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) MAX BLOCK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 26 1982 2b. HOUR 5³³ P^M | | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 18, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCCER | | 12b. KIND OF BUSINESS OR INDUSTRY MERCHANT | |
| 13a. STATE D. C. 13b. COUNTY NONE | | | | | 13c. CITY OR TOWN WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BLOCK | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA BERRY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 577-03-3443 | | 17. INFORMANT 1120 HAMILTON STREET, N. E. BERTHA BLOCK, WASHINGTON, D. C. 20011 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cordiac Arrest (b) Myocardial infarction (c) Renal nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/25 - 9/26 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/26 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 82 to 9/26 19 82 , that (I) (we) last saw the deceased alive on 9/26 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE Penny Bisk | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 23b. DATE SIGNED 9/27/82 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY BISK | | | | 23d. ADDRESS 8630 FENTON ST. Silver Spring MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 9/29/1982 | | 23c. NAME OF CEMETERY OR CREMATORY OHED SHULOM TALMUD TORAH CONGREGATION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C. | | | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | |
| 23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3

MEDICAL CERTIFICATION

BP _____
DHMH - 17
(VR A15 ME (5)
20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

LIBRETS

NO

1000

W

(1000)

Handwritten signature or text

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24-hour return with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as new, 18 hours after any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 3 9 9 5 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| DECEASED NAME FIRST MIDDLE LAST Tillie Bodnick | | | | 9 26 82 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 30, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN MONTGOMERY | | 13c. STREET ADDRESS 6121 MONTROSE ROAD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (UNASCERTAINABLE) | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNASCERTAINABLE) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 578-01-1260 | | 17. INFORMANT ADDRESS JERRY B. BODNICK, 15210 ELKRIDGE WAY, APT. 3C SILVER SPRING, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Coronary Pulm arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible acute myo-</u> underlying cause last <u>cardial infarction</u> (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/26/82</u> 19 <u>82</u> to <u>9/26/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/26/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE H. O. Rhiamey | | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 9/27/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. O. RHIAMEY | | | | 22f. ADDRESS 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 9/29/1982 | | 23c. NAME OF CEMETERY OR CREMATORY NATIONAL CAPITOL HEBREW CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C. | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | |
|--|--|--|-------------------|--|----------|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| FIRST MARYNA | | | MONTH 9 | | DAY 16 | | |
| MIDDLE BOLABIO | | | YEAR 82 | | 11 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | MONTH 11 | | DAY 12 | |
| | | | | YEAR 1887 | | 94 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| VIENNA AUSTRIA | | AUSTRIA | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | BETHESDA HEALTH Center | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Md. | | Montgomery | | Silver Spring | | 8201 16th St. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Leopold | | Ernestine | | NO | | 099-28-5285 | |
| 17. INFORMANT | | 18. ADDRESS | | 19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. STREET ADDRESS | |
| Paul Hirsch | | 8201 - 16th Street; SSpg, Md. | | | | 20910 | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 22. IMMEDIATE CAUSE (a) | | 23. DUE TO, OR AS A CONSEQUENCE OF (b) | | 24. DUE TO, OR AS A CONSEQUENCE OF (c) | |
| 4360 | | cerebral vascular accident | | anoxia brain syndrome | | cerebral arteriosclerosis | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 34. LOCATION STREET | | 35. CITY OR TOWN | |
| | | | | | | 36. COUNTY | |
| | | | | | | 37. STATE | |
| 38. I certify that (I) (this hospital) attended the deceased from 6 Sept 1982 to 6 Sept 1982, that (I) (we) last saw the deceased alive on 6 Sept 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | 39. SIGNATURE | | 40. DEGREE | | 41. DATE SIGNED | |
| | | John J. DAVEN | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 6 Sept 82 | |
| 42. PHYSICIAN'S NAME (TYPE OR PRINT) | | 43. ADDRESS | | 44. NAME OF CEMETERY OR CREMATORY | | 45. LOCATION CITY OR TOWN | |
| JOHN J. DAVEN | | 7505 Denman Rd Bethesda Md. | | Lee Crematory | | Washington, D.C. | |
| 46. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 47. DATE | | 48. NAME OF CEMETERY OR CREMATORY | | 49. LOCATION CITY OR TOWN | |
| Cremation | | 9-8-82 | | Lee Crematory | | Washington, D.C. | |
| 50. FUNERAL DIRECTOR NAME | | 51. ADDRESS | | 52. DATE REC'D. BY REGISTRAR | | 53. REGISTRAR'S SIGNATURE | |
| Danzansky-Goldberg Chapels | | 1170 Rockville Pike | | SEP 9 1982 | | John J. DAVEN | |

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15. 08-1 12-2

St. Mary's Hospital

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5085.070

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 3 9 9 7 | | | |
|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH H NMI BOLDOGH | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 24 1982 | | 2b. HOUR 8³⁰ P M | |
| 3. SEX FEMALE | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR May 22, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paul Telegdy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Lindiger | | 13e. STREET ADDRESS 6313 Herkos Court 20817 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-30-1491 | | 17. INFORMANT ADDRESS Raymond F. Stone, same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Largest heart failure 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Kidney failure (c) Hypertrophic myocardiopathy | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week 4 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 9/29 , 19 69 , to Sept. , 19 82 , that (I) (we) last saw the deceased alive on 9/29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Earl M. Morell DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. MORELL | | | | 22e. ADDRESS 6000 EXECUTIVE BLDG, ROCK, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

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CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT) PEARL IRENE BROWN BRANDS
Pearl B. Brands2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
SEPT. 15 82 2:30AM3. SEX
Female4. RACE
Cauc.5. DATE OF BIRTH
MONTH DAY YEAR
June 4, 1908

6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD.10. CITY OR TOWN OF DEATH
Olney11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher12b. KIND OF BUSINESS OR INDUSTRY
Pub. Schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland13b. COUNTY
Montgomery13c. CITY OR TOWN
Silver Spring13d. INSIDE CITY LIMITS?
YES ☐ NO ☒13. STREET ADDRESS
15300 Pine Orchard Dr. 2A 2090614. FATHER'S NAME
FIRST MIDDLE LAST
James Thomas Brown15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hettie Lourina Pefley16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no16b. SOCIAL SECURITY NO.
254-24-990817. INFORMANT
ADDRESS
Edwin Brands same as 1318. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Atherosclerotic Vascular DiseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH8 weeks

4360

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) SFD/4

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Fever of unknown origin.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (1) (this hospital) attended the deceased from 9/26, 19 82, to 9/14, 19 82, that (1) (we) lost
saw the deceased alive on 9/12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

A. ROTSTEIN

22e. ADDRESS

3701 Rossmore Ave
S. Spring Ln 20906

23a. BURIAL, CREMATION, REMOVAL

Cremation

23b. DATE

Sept. 16, 1982

23c. NAME OF CEMETERY OR CREMATORY

Lee Funeral Hm.23d. LOCATION
CITY OR TOWNWashington, D.C.

24. FUNERAL DIRECTOR

NAME

FRANCIS H. BARBER

ADDRESS

P.O. Box 998
Laytonsville, Md.

25a. DATE REC'D. BY REGISTRAR

SEP 20 1982

25b. REGISTRAR'S SIGNATURE

John J. Carver

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cleared by medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 3 9 9 9 | | | |
|--|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ruth Ann Brandt | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 10, 1982 | | 2b. HOUR 3:10p | |
| 3. SEX female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR January 8, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4302 Dresden St zip: 20895 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur James Parker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisey Cornelia Deaton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-30-2310 | | 17. INFORMANT ADDRESS Matthew C. Brandt, Husband, Same as item #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from September 10, 1982 to September 10, 1982 , that (I) (we) lost saw the deceased alive on September 10, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Barry Hecht | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Sept. 10, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HECHT | | | | 22e. ADDRESS 3929 FERRARA DRIVE WHEATON, MARYLAND 20866 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 0 0 0 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dr. Elizabeth G. Brings | | | | 2b. HOUR 7 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 22, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11616 Danville Drive | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician | | 12b. KIND OF BUSINESS OR INDUSTRY Own Practice | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Allegany | | 13c. CITY OR TOWN La Vale | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edmund Waldstein | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paula Weiner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 214-46-3152 | | 17. INFORMANT ADDRESS Marlene E. Haffner M.D. Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE 5070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 20 , 19 82 , to AUG 7 , 19 82 , that (I) (we) lost saw the deceased alive on JULY 31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE MORGAN D. DELANEY | | | | DEGREE PHYSICIAN | | 22c. DATE SIGNED 9/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORGAN D. DELANEY | | | | 22e. ADDRESS 2150 PENNSYLVANIA AVE. N.W., WASH. D.C. 20037 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR NAME James F. Scarpelli | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | | |

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11. 11. 1950, 11. 11. 1950, 11. 11. 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 0 1 | | | |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FLORENCE BRISSETT | | | | 9 18 82 2 22 PM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH Sept. 18, 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD | | USA | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hospital | | N/A | | N/A | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | |
| Md. | | Montgomery Wheaton | | 11407 Sherrie Lane 20902 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Norman W. Brissett | | BARBARA Walker | | No | | N/A | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | | 20. AUTOPSY? | |
| 11407 Sherrie Lane | | Die Maturity | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Norman W. Brissett Wheaton, Md. 20902 | | PART I. DEATH WAS CAUSED BY: | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | 7651 IMMEDIATE CAUSE (a) | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | (b) | | | | 21f. LOCATION | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | CITY OR TOWN COUNTY STATE | |
| | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED | | 22d. ADDRESS | |
| saw the deceased alive on 5:20 PM 9/18/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I (we) did) (did not) view the body after death. | | Ralph Stiller | | 9/18/82 | | 1111 Springs Creek SS Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 9/23/82 | | Gate of Heaven Cem. | | Silver Spring Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. | | SEP 27 1982 | | J. C. C. C. | | | |

1. *What is the main purpose of the study?*

235

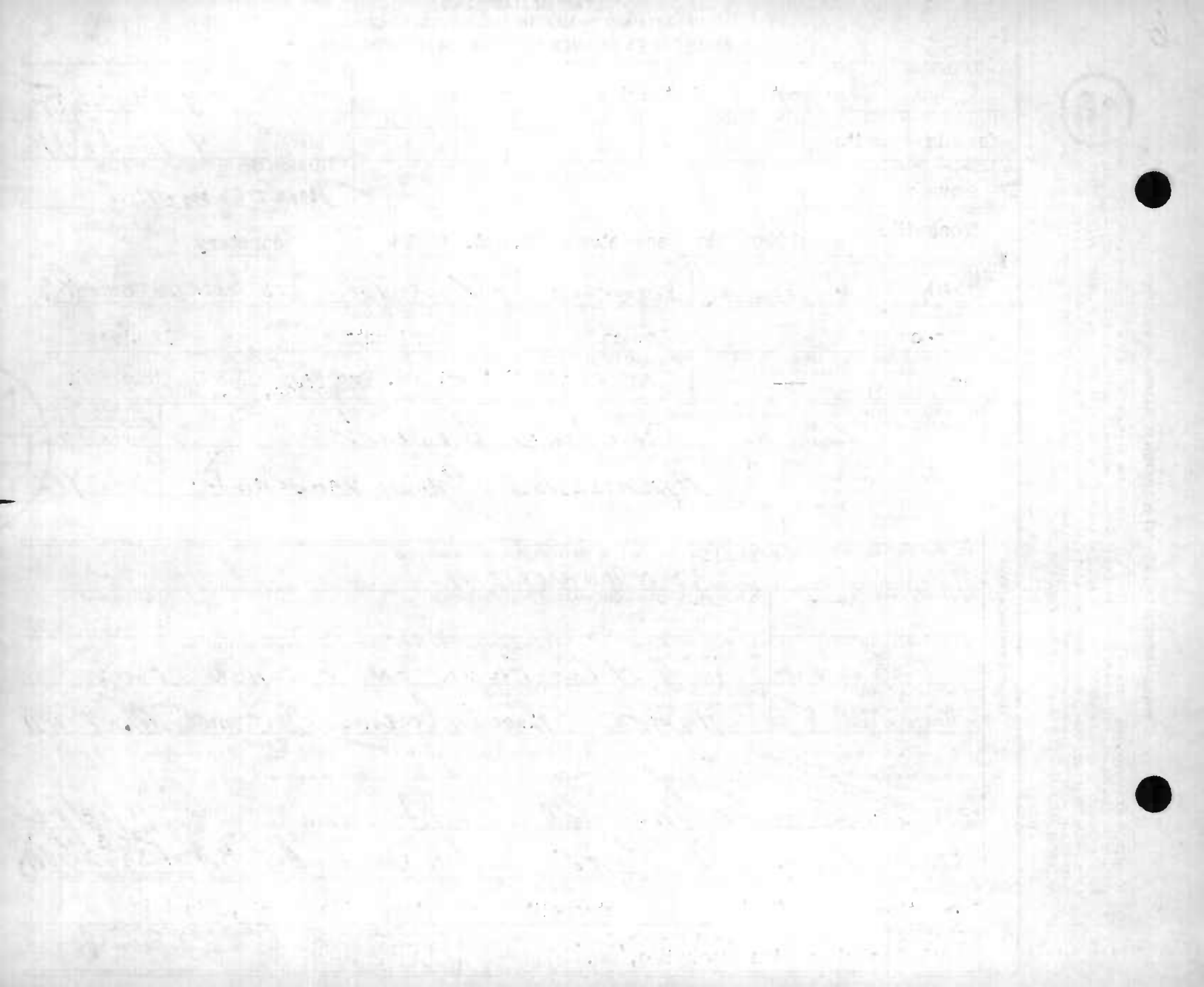
5891, 81. 1997

742093

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE THE CERTIFICATE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 2 2 4 0 0 2 | |
|--|--|---------------------------|--|--|--|--|--|---|--|--|--|----------------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Catherine Brosseau | | | | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 9 14 19 82 | | | | 2b. HOUR 4 45 PM | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 7 3 32 | | 6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS. | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 9 16 19 82 4 45 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nevada | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12000 Old Georgetown Rd. Apt. #1002N | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12000 OLD GEORGETOWN RD | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roseuda Gomez | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Enriqueta Ramirez | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 549 42 7296 | | 17. INFORMANT ADDRESS Catherine I. Brosseau 3805 Randolph Rd. Wheaton, Md. 20902 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>HYPERTENSIVE CARDIO VASCULAR DIS</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>3-5 YRS</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>ETHANOLISM</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 14 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>FOUND ON KITCHEN FLOOR</u> | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>HOME</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>12000 Old Georgetown Rd Bethesda Mont Md</u> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | TITLE (SPECIFY) <u>DEPT</u> | | | | DATE SIGNED <u>9/16/82</u> | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>FRANCIS C. WARE</u> | | | | ADDRESS <u>600 W. WASHINGTON ST. BETHESDA MD</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 9/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |



Cleaned and signed by Dr. Rogers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 0 0 3 | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | | | | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | | | |
| Margaret M BRUMFIELD | | | | | | | | | | 9 - 26 - 82 | | | |
| 3. SEX | | | | | | | | | | 5. DATE OF BIRTH | | | |
| Female | | | | | | | | | | MONTH DAY YEAR | | | |
| white | | | | | | | | | | 12 25 08 | | | |
| 7a. BIRTHPLACE | | | | | | | | | | 6. AGE | | | |
| North Carolina | | | | | | | | | | 73 | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. AGE (IN YEARS LAST BIRTHDAY) | | | |
| U.S.A. | | | | | | | | | | YRS. MONTHS DAYS HOURS MIN. | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Silver Spring | | | | | | | | | | MONTGOMERY MD. | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | | | | | | | 12a. USUAL OCCUPATION | | | |
| Holy Cross Hosp | | | | | | | | | | Sales Clerk | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | 12c. STREET ADDRESS | | | |
| Dept. Store | | | | | | | | | | 2212 Prickard Road | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | | |
| Md. | | | | | | | | | | Wheaton | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | | | |
| James Edward Mue | | | | | | | | | | Mattie Atkinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | |
| No | | | | | | | | | | 237-18-2829 | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | | | |
| Virginia M. Fleichman | | | | | | | | | | D.C. Wash. | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | | 3 | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Cardiopulmonary arrest | | | |
| 4140 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Congestive Heart failure | | | |
| | | | | | | | | | | (c) Acute Ischemic Heart Disease | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| YES NO | | | | | | | | | | YES NO | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY | | | |
| WHILE AT WORK NOT WHILE AT WORK | | | | | | | | | | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 82, to 9/26 19 82, that (II) (we) last saw the deceased alive on 9/26/82 19 82, and that (III) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE | | | |
| 22c. DATE SIGNED | | | | | | | | | | 22d. PHYSICIAN'S NAME | | | |
| 9/26/82 | | | | | | | | | | THOMAS H. BURGHIERES MD. | | | |
| 22e. ADDRESS | | | | | | | | | | 22f. DATE RECD. BY REGISTRAR | | | |
| Holy Cross Hospital, Emergency Dpt. | | | | | | | | | | 9/26/82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. DATE | | | |
| Cremation | | | | | | | | | | 9/27/1982 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | |
| Cedar Hill Crematory | | | | | | | | | | Suitland Maryland. | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE RECD. BY REGISTRAR | | | |
| Joseph Cawler's Sons Inc. | | | | | | | | | | 9/27/1982 | | | |
| 5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | | John J. Canine | | | |

Operation 9/27/82 Cedar Hill Crematory Building Maryland
 Joseph A. Lee, Jr. Inc.
 210 Lee Ave., N.E., Wash., D.C.

No 207-18-5029 Virginia M. Leichman 2113 Ross St., Wash.
 D.C.

James Marie Mattie Addison

Ma. Mont. Wheaton

2212 Pickard Road

2117 Cross Road

John Clerk

2017 St.

North Carolina U.S.A.

2017 St.

Female White

12 20 10

13

PRINTED

Harvard N. M.

2017 St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

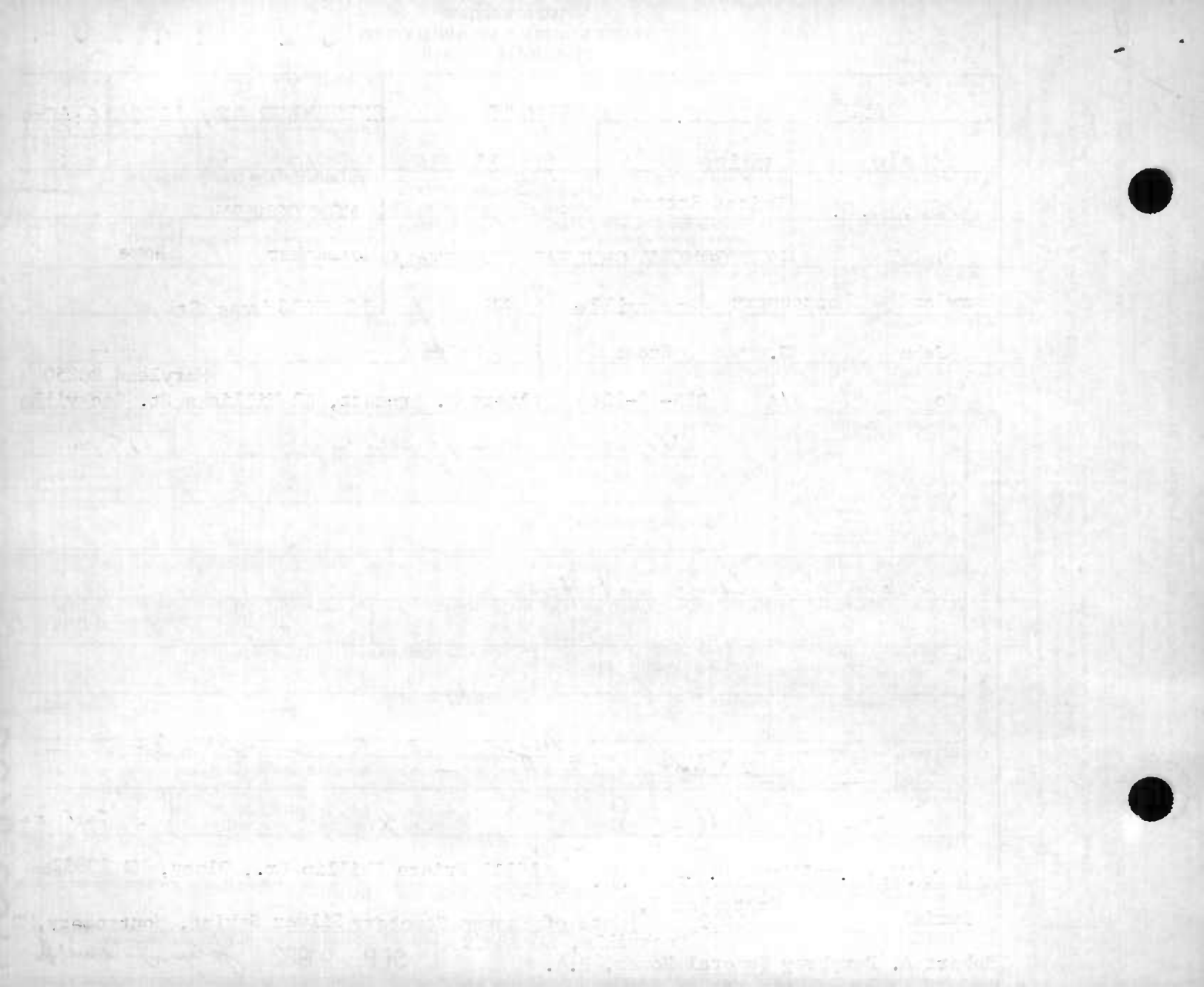
8 2

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REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANN S. BRUNETT | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2, 1982 | | 2b. HOUR 6:40 PM |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 8 31 34 | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | |
| 10. CITY OR TOWN OF DEATH OLNEY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Rockville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John G. Stone | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Ramey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. N/A | 17. INFORMANT ADDRESS Maryland 20850 | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 18b. SOCIAL SECURITY NO. 222-20-1386 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Brain and lung metastasis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 81 , to 2 Sept , 19 82 , that (I) (we) lost saw the deceased alive on 2 Sept , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Donald E. Dillon MD | | DEGREE M.D. | | 22c. DATE SIGNED 3 Sept 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. DILLON M.D. | | 22e. ADDRESS 18111 Prince Phillip Dr., Olney, MD 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE September 7, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Montgomery, MD | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. | | ADDRESS Rockville, MD 20850 | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 0 0 5 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARJORIE GORDON BUCHANAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1 1982 | | | 2b. HOUR 2:03 PM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 10 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA UNITED STATES | | 9. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 12. CITY OR TOWN OF DEATH BETHESDA | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 15. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DISTRICT OF COLUMBIA | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3900 WATSON PLACE, NW | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT BOLLING BROWN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA ANISE GEARY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-60-4243 | | 17. INFORMANT ADDRESS ANN B. REGAN, 9600 FERRY HARBOR COURT, ALEXANDRIA, VA 22309 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7855 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 1 19 82 to SEPTEMBER 1 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 1 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Michael M. Van Ness</i> LT, MC, USNR | | | | | 22c. DATE SIGNED 25 SEP 82 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL VANNESS, LT, MC, USNR | |
| 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/3/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D. C. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 REGISTRAR'S SIGNATURE <i>John J. Gawler</i> | | | | |

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Cleared by Dr. Roger's Medical Examiner.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 4 0 0 6 CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy S. Burdette | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR September 7 1982 4:40 P.M. | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 8, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Damascus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 25710 Ridge Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Archie W. Souder | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie L. Purdum | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 219-36-8392 | | 17. INFORMANT ADDRESS Roger W. Burdette, Jr. Item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Metastasis in pelvis & abdomen | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 19 79 to 7 Sept 82 , that (1) was lost saw the deceased alive on 24 Aug 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Donald E. Dillon M.D. | | | | | 22c. DATE SIGNED 7 Sept 82 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D. | | |
| 22e. ADDRESS 18111 Pr Philip Dr Olney, Md 20832 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Damascus Montg. MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Calkins | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 1B, there is only injury, or other traumatic event, the medical examiner is notified and a medical certificate is required.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 0 0 7 | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| James D. Burdette | | | | September 21, 1982 | | | | 3:25 PM | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | Oct. 31, 1897 | | 84 YRS. | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Olney | | Montgomery General Hospital | | | | Farmer | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland Frederick Mt. Airy, 21771 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13116 Old National Pike | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| George W. Burdette | | | | Violet G. Mullinix | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | | | ADDRESS | |
| No | | | | 215-34-3481 | | Dorine Burdette, | | | | Item 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 7 4860 IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | | | DAYS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | | | |
| DEHYDRATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from September 20, 19 82, to September 21, 19 82, that (I) (we) lost saw the deceased alive on September 21, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Barry Hecht | | | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | September 21, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| BARRY HECHT | | | | 3929 FERRARA DRIVE WHEATON, MD 20906 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | Sept. 24, 1982 | | Montgomery Meth. | | Damascus, Montgomery, Md. | | | |
| 24 FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Olin L. Molesworth, P.A., Damascus, Md. | | | | SEP 27 1982 | | | | John J. Lohr | | | |

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| 1987, 31, 1887 | Life | Life |
| x | ADU | ADU |
| 1987, 31, 1887 | Life | Life |
| x | ADU | ADU |
| 1987, 31, 1887 | Life | Life |
| x | ADU | ADU |
| 1987, 31, 1887 | Life | Life |
| x | ADU | ADU |
| 1987, 31, 1887 | Life | Life |
| x | ADU | ADU |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 50M 1/81
(VRA 1S, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 0 0 8 | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET BURNS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-13-82 | | | | 2b. HOUR 1:15 P | | | |
| 1. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 3 02 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5480 WISCONSIN AVE #27 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Ellis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Quigley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 092 09 0377 | | 17. INFORMANT Son ADDRESS Edward J. Burns, Jr. 415 G Street SW Washington DC | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal + Pulmonary Failure 1560 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) operation for Resection of CA + Gall bladder (c) irradiating liver, colon, + duodenum | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/3/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11 , 19 82 , to 9/13 , 19 82 , that (I) (we) lost saw the deceased alive on 9/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE W. Marcus DEGREE MD | | | | | | | | 22c. DATE SIGNED Sept. 14, 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Y. Marcus, M.D. | | | | | | | | 22e. ADDRESS 10301 Georgia Avenue Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bronx, New York | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conish | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 2 4 0 0 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND | | | | | | | | | | 2a. DATE KNOWN OF DEATH Sept 4 1982 | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX M | | | | | | | | | | 4. RACE W | | | | | | | | | | 5. DATE OF BIRTH 2 4 29 | | | | | | | | | | 6. AGE (IN YEARS) 53 | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA | | | | | | | | | | 10. CITY OR TOWN OF DEATH Sil. Spg | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY MARKETING CO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | | | | | | | | | 13b. COUNTY Mont. | | | | | | | | | | 13c. CITY OR TOWN Sil. Spg | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 3123 Valleywood Dr | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME RAYMOND | | | | | | | | | | 15. MOTHER'S MAIDEN NAME PERMELIA | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | | | | | | | 16b. SOCIAL SECURITY NO. 1951-1953 | | | | | | | | | | 17. INFORMANT ELIZABETH J. BUSHNELL | | | | | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 Acute Myocardial Inf | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | TITLE (SPECIFY) Regis M.D. Dep MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED Sept 4 1982 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE JOHN S. ROGERS | | | | | | | | | | EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | | | | | | | 23b. DATE 9-5-82 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREM | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX VA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS | | | | | | | | | | 500 UNIVERSITY BLVD. WEST ADDRESS SILVER SPRING, MD. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1982 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

JOHN S. ROGERS

9-5-88 METROLOGICAL CORP.
500 UNIVERSITY BLVD. WEST
SILVER SPRING, MD.

CEMENTATION
FRANCIS J. COLLINS

ALEXANDRIA FAIRFAX VA

10274

266-36-2988 ELIZABETH J. BUSHWELL
13123 VALLIEWOOD DR.
BETHESDA

RAYMOND

O.

BUSHWELL

BETHESDA

FLORIDA U.S.A.

28 1 2

O.

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PRESIDENT MARKETTING

*TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 0 1 0 REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) WILLIAM JOSEPH BUTLER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 9 1982 | | | 2b. HOUR 7:20 p.m. | |
| 3 SEX MALE | | 4 RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 20 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK AND MANNER OF WORKING LIFE) Officer (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 109 OXFORD STREET | |
| 14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL BUTLER | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE LOONEY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. 1911-1946 577-52-1663 | | 17. INFORMANT ADDRESS CARO H. BUTLER, 109 OXFORD STREET, CHEVY CHASE, MD 20815 | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 20 , 19 82 , to SEPTEMBER 9 , 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I do) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>K.C. Karvelis</i> | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 10 Sep 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.C. KARVELIS, LT, MC, USNR | | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/14/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | | |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME 5130 Wisc. Ave., N.W. Wash. D.C. ADDRESS | | | | | 25. DATE RECEIVED BY REGISTRAR 26. REGISTRAR'S SIGNATURE SEP 15 1982 John J. Gawler | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 1 1 | |
|--|--|---|--|--|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Alice LEE Buxbaum | | | | | | 2a DATE OF DEATH MONTH DAY YEAR 9-8-82 | | | 2b HOUR 10¹⁶ AM | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH October 25, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b CITIZEN OF WHAT COUNTRY? United States | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Bethesda | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker/Mother | | | 12b KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a STATE Maryland | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Bethesda | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 7819 Custer Road (20814) | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John A. Lyons | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Randall | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b SOCIAL SECURITY NO. 578-05-5199 | | 17 INFORMANT ADDRESS Martin D. Buxbaum, same as #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 2780 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Gross obesity | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 week 10 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 9-3 , 19 82 , to 9-7 , 19 82 , that (I) (we) lost saw the deceased alive on 9-7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Eva M. Morell | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 9-8-82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) EVA M. MORELL | | | | | | 22e ADDRESS 6000 Executive Blvd. Rockville, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE Sept. 11, 1982 | | 23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | | | ADDRESS Bethesda, Maryland 20814 | | 25a DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b REGISTRAR'S SIGNATURE John J. Condit | |

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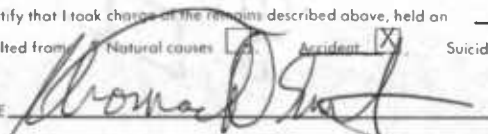

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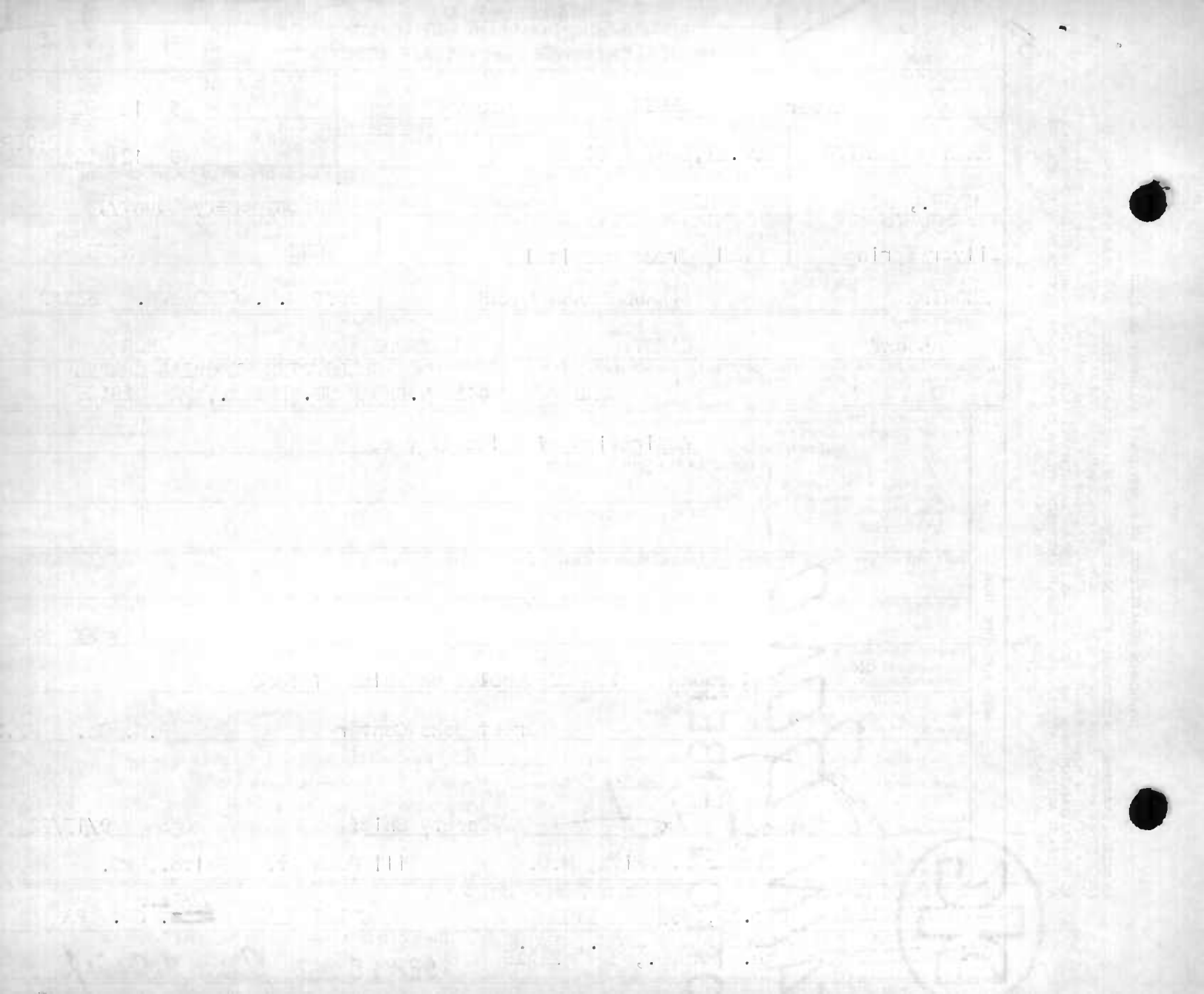
10-11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH OTHER FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24012 | |
|---|------------------|---|---|--|--|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward BRUCE Capet | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 12 1982 | | 2b. HOUR M 2:08P | | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1947 | 6. AGE (IN YEARS) LAST BIRTHDAY 34 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 9 12 1982 | 7d. HOUR M 2:08P | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | | | | |
| 13a. STATE FLORIDA | | 13b. COUNTY | | 13c. CITY OR TOWN LAUDERDALE LAKES | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3990 N.W. 42ND AVE. #33319 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALBERT CAPET | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BERG | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT GOLDSTEIN'S MEMORIAL CHAPEL 6410 N. BROAD ST. PHILA., PA 19126 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of bolus of food</u> 9110 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50xx 9 12 1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Choked on bolus of food | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Great Oaks Center P.G. Co. MD. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | TITLE (SPECIFY) M.D. Deputy Chief | | | MEDICAL EXAMINER | | | DATE SIGNED 9/13/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL | | | 23b. DATE SEPT. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HAR ZION | | | 23d. LOCATION CITY OR TOWN COUNTY STATE COTTINGDALE DEL. CO. PA | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD. 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

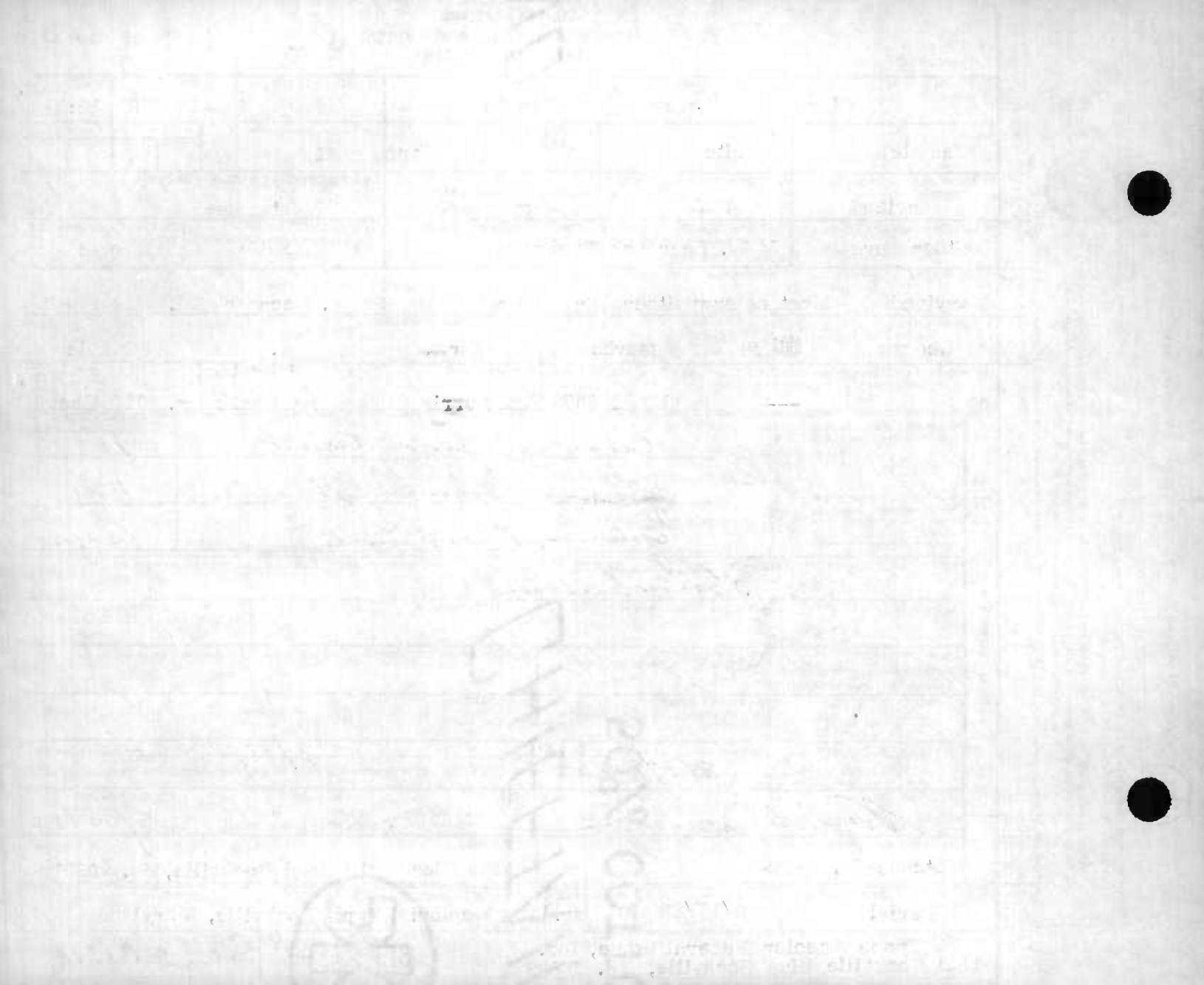
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 1 3 REG. NO. | |
|---|--|--|--|---|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Clara Rebecca Caponera | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 14 82 | | 2b. HOUR 12:05 a. M | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 2 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 54 W. Deer Park Road #204 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Gaithersburg | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George William Mayhew | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Mobley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. --- 217 22 8073 | | 17. INFORMANT 20815 Maryland Chase, Ann Norris 4750 Chevy Chase Dr. #112 Chevy | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> 18 yrs | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15' | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/67</u> , 19 <u>82</u> , to <u>9/18/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/24/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stephen N. Jones</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 9/20/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones | | 22e. ADDRESS 809 Viers Mill Road Rockville, Md. 20851 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park Rockville, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>John E. Carver</u> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 0 1 4 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ANITA ZERING CARLSEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18 1982 | | | 2b. HOUR 9:27a _M | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH JANUARY 5 1907 ^R | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, NMMC | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE FLORIDA | | 13b. CITY OR TOWN MONROE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2811 HARRIS AVENUE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK - ZERING | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE BARBARA ATKOCHITIS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS 3006 STAUNTON ROAD ELEANOR CARLSEN MOSER HUNTINGTON, W.VA. 25702 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2041 IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>26 JULY</u> 19 <u>82</u> to <u>18 SEPTEMBER</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>18 SEPTEMBER</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Richard L. Furman</i> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 18 SEP 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L. FURMAN, LCDR, MC, USNR | | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MARYLAND 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



10

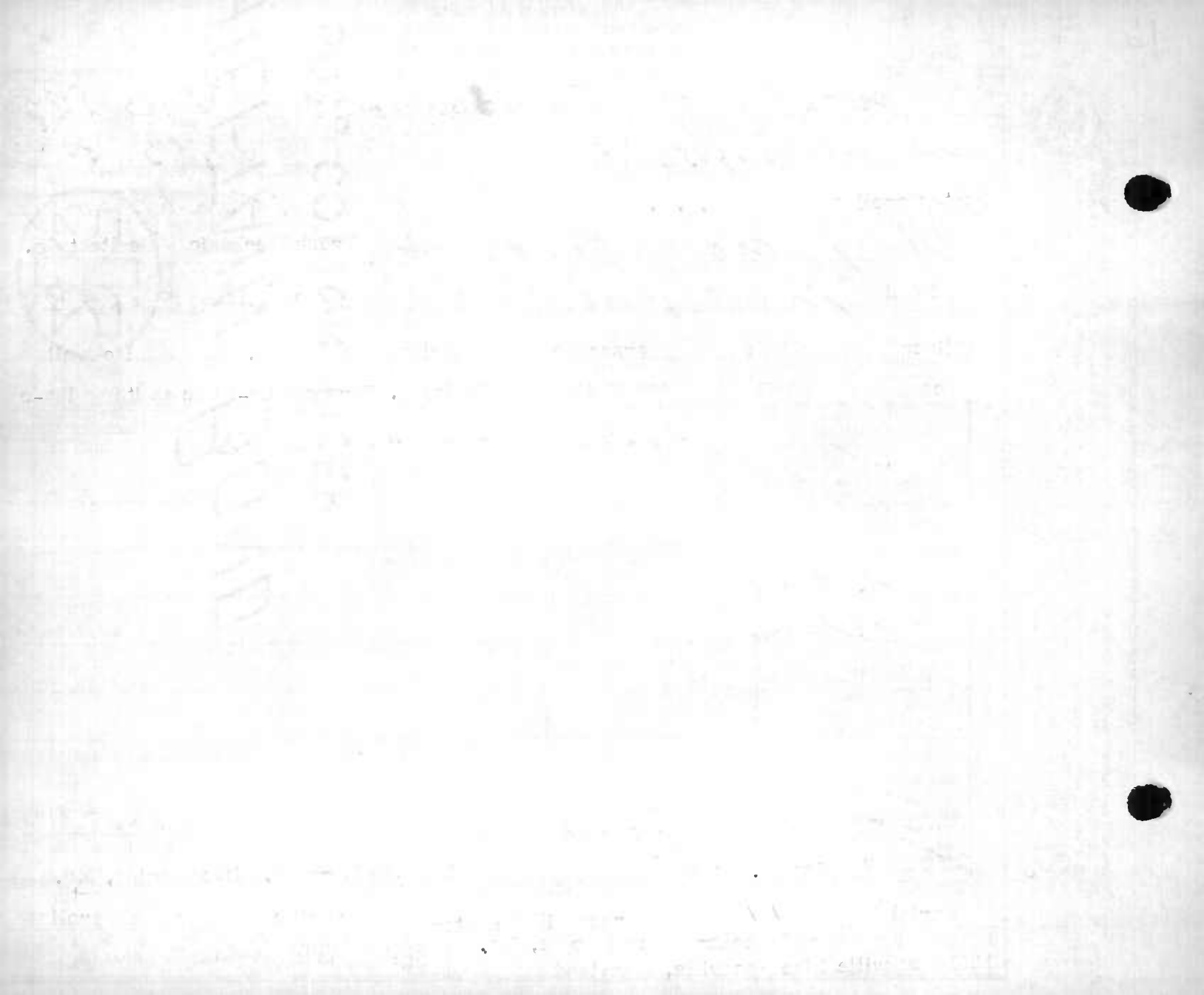


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24015 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Werley Irl Carscaddon | | | | | | | | | | 2. DATE KNOWN OF DEATH Sept 3 1982 | |
| 3. SEX Male 4. RACE White 5. DATE OF BIRTH May 15 1961 6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | | | | | | | | 2c. DATE PRONOUNCED DEAD Sept 3 1982 | |
| 10. CITY OR TOWN OF DEATH Olney 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Mechanic 12b. KIND OF BUSINESS OR INDUSTRY Sealtest Co. | | | | | | | | | | | |
| 13a. STATE MD 13b. COUNTY Mont 13c. CITY OR TOWN Rockville 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS 13705 Rockledge Dr | | | | | | | | | | | |
| 14. FATHER'S NAME (TYPE OR PRINT) Oliver Clyde Carscaddon 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Ovia J. Blackwell | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. WWII 16c. DATE OF DEATH 237 26 4083 17. INFORMANT Janice D. Carscaddon - Same as items 13a-e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) None PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) None 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers TITLE (SPECIFY) MD MEDICAL EXAMINER DATE SIGNED Sept 3 1982 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers ADDRESS 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9/7/82 23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Ashville Buncombe North Carolina | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler ADDRESS Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 25. DATE REC'D. BY REGISTRAR SEP 9 1982 REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 1 6 REG. NO. | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred Barkley Castle, Jr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 10 1982 | | | | 2b. HOUR 3:00 P.M. | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director | | 12b. KIND OF BUSINESS OR INDUSTRY C.P.S.C. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alfred Barkley Castle, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Tolson | | | | 16. SOCIAL SECURITY NO. 679-38-2476 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) Korea | | | | 17. INFORMANT ADDRESS M. Jocelyn Castle, Wife, Same as item #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) LUNG CARCINOMA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT WORK) (AT WORK) | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV-81 , to SEPT 10, 1982 , that (I) (we) last saw the deceased alive on SEPT 10, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Eugene P. J. Flannery | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene Flannery, M.D. | | | | 22e. ADDRESS 18111 PRINCE PHILIP DR. OLNEY, MD 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Sept. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 1 7 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lizzie Carter | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1982 | | 2b. HOUR 5:15pm M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR June 12, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 98 yrs | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.E. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital ER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Cook | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY Maryland P.G. Fairmont Hts. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 906 60th Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Carter | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louvinia (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT ADDRESS Emma James-Same as # 13 above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 0389 IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Possible Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Coronary Artery Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 26 Sep 82 , to 26 Sep 82 , that (1) (we) last saw the deceased alive on never 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |
| 22b. SIGNATURE P. Buttarandi | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 26 Sep 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Buttarandi | | 22e. ADDRESS HCH Emergency Dept. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 10-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE HIGHLAND PARK MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | |

618

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 1 8

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE V. LAST CEFARATTI | | | 2a. DATE OF DEATH MONTH SEP. 10, 1982 DAY YEAR | | 2b. HOUR 9:30 A M |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH 07 DAY 28 YEAR 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH MARYLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12610 GOULD ROAD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY N.I.H. |
| 13a. STATE MARYLAND | | | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN WHEATON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST THOMAS MIDDLE KOHLENBURG LAST | | | 15. MOTHER'S MAIDEN NAME FIRST GEORGIA MIDDLE E. LAST TURNER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-28-8890 | | 17. INFORMANT DAUGHTER SHERRY L. SCHWENK | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary - lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/17</u> , 19 <u>76</u> , to <u>7/29</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>A. F. Thibadeau MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. THIBADEAU, M.D. | | 22e. ADDRESS 10111 COLESVILLE RD. SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON PR. GEO. MD. | | 23e. DATE REC'D. BY REGISTRAR SEP 16 1982 | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | 25. REGISTRAR'S SIGNATURE <u>Joan J. Conner</u> | | | |

MEDICAL CERTIFICATION



0212

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Handwritten text, possibly a signature or name, written in cursive script.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and examined prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 1 9 REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Robert A.A.J.L. CHAPPELLE</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 4 82</i> | | 2b. HOUR <i>7:50 A.</i> | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 16, 1928</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>54</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. | |
| 10. CITY OR TOWN OF DEATH Damascus | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10509 Bethesda Church Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professional | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Damascus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Chappelle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Keen | | 13e. STREET ADDRESS 10509 Bethesda Church Rd. 20872 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. W.W. 2 229-42-0086 | | 17. INFORMANT ADDRESS Lois Jean Chappelle, Item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 Mesothelioma IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH June '81 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Fred A. Hall</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/4/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.A. Hall | | 22e. ADDRESS 4743 Bradley Blvd Chevy Chase Md | | 22f. _____ | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Greenwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bedford, Virginia | |
| 24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., | | | | 25a. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE SEP 9 1982 John L. Church | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the official cause must be indicated on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 2 4 0 2 0 REG. NO. | | | | | | |
|--|--|--|--|---|---|---|--|---|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>MARTHA C. CHILDS</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>9 3 82</u> | | | | | 2b. HOUR <u>2:15 AM</u> | |
| 3. SEX <u>FEMALE</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>7 2 96</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, D. C.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS OF SILVER SPRING</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>MD.</u> | | 13b. COUNTY <u>Pr. Geo.</u> | | 13c. CITY OR TOWN <u>HAITSVILLE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>6500 Eggs RD.</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Walter Scott Welborne</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elie Beckley</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <u>579-60-4159</u> | | 17. INFORMANT ADDRESS <u>Doris Parker, niece, Washington, D.C. 1020 Quebec Pl. N.W.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4860</u> IMMEDIATE CAUSE (a) <u>acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 days</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>ASCVD, Atrial Fibrillation</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>12-7-81</u> , 19____, to <u>9-3-82</u> , 19____, that (I) (we) last saw the deceased alive on <u>9-3-82</u> , 19____, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>MB Patnick MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9-3-82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G B Patnick MD</u> | | | | 22e. ADDRESS <u>4221 Coleridge Rd Silver Spring, Md 20910</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Sept. 8, 82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, P.G., Maryland</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>McGuire Funeral Service, Inc. Wash. DC 20012</u> | | | | 7400 Georgia Ave. NW | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 14 1982 John J. Connel</u> | | | |



100% COTTON YARN

12-3-87

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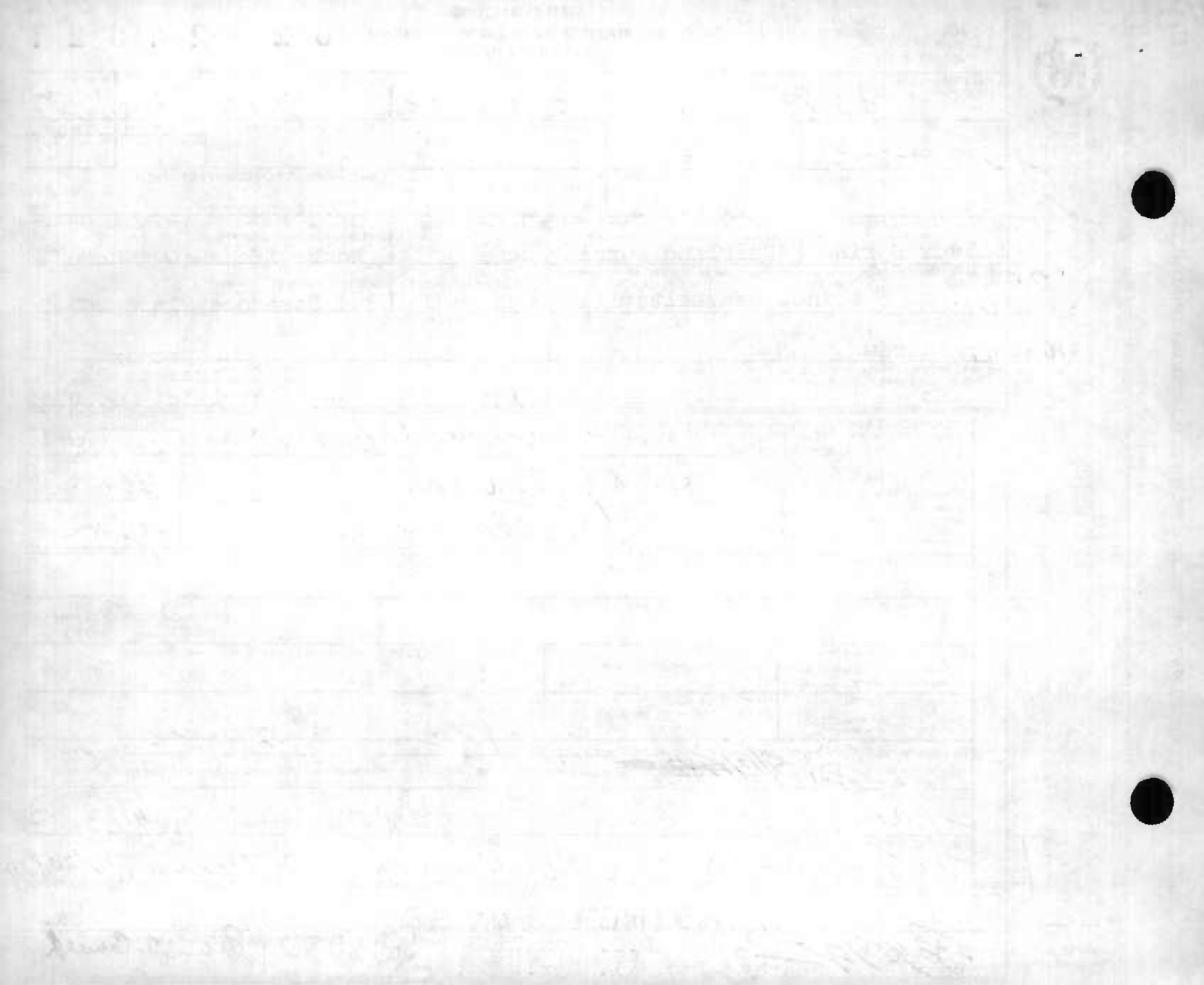
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must certify the cause of death.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|--------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 8 2 2 4 0 2 1 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ANNA K. CIELENSKY | | | | 9/13/82 | | | | | | 1650 | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | | | |
| FEMALE | | WHITE | | 9 MONTH DAY YEAR | | 79 YRS. | | MONTHS | | DAYS | | HOURS MIN. | |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b CITIZEN OF WHAT COUNTRY? | | 10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Pa. | | U. S. A. | | | | Montgomery | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | Fairland Nursing Home | | Housewife | | Own Home | | | | | | | |
| 13a STATE | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? | | 13d STREET ADDRESS | | | | | | | |
| Md. | | Prince Geo. Beltsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4304 Sarasota Place 20705 | | | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17 INFORMANT | | | | | | | |
| Andrew | | Anna | | No | | 4304 Sarasota Pl. | | | | | | | |
| 18 | | 19 | | 203-36-3624 | | Rita Rock - Dtr. Beltsville, Md. 20705 | | | | | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I: DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a): | | | | | | | | | | 6 months | | | |
| 4360 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | years | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| (b): | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | years | | | |
| (c): | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | |
| 11a DATE OF OPERATION | | | | 11b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 11c AUTOPSY? | | 11d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 12a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 12b TIME OF INJURY | | | | 12c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 13a INJURY OCCURRED | | | | 13b PLACE OF INJURY | | | | 13c LOCATION | | 13d CITY OR TOWN | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | | | | | |
| 14 I certify that (1) the hospital attended the deceased from 9/10/82 to 9/13/82, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (2) I was (did not) see the body after death. | | | | | | | | | | | | | |
| 15 SIGNATURE | | | | DEGREE | | | | 15b DATE SIGNED | | | | | |
| Thos G. Ward | | | | | | | | 15b DATE SIGNED | | 9/13/82 | | | |
| 16 PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 16b ADDRESS | | | | 16c DATE SIGNED | | 16d REGISTRAR'S SIGNATURE | | | |
| Thos G. Ward | | | | 6116 Raherwood, Bethesda, Md 20817 | | | | | | | | | |
| 17 BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 17b DATE | | 17c NAME OF CEMETERY OR CREMATORY | | 17d LOCATION | | 17e COUNTY | | 17f STATE | |
| Burial | | | | 9/17/82 | | Laurel Point Cemetery Carmichaels, Pa. | | | | | | | |
| 18 FUNERAL DIRECTOR | | | | 18b ADDRESS | | 18c DATE SIGNED | | 18d REGISTRAR'S SIGNATURE | | | | | |
| Warner E. Pumphrey, Inc. | | | | P. O. Box 7428 Sil. Spr., Md. | | SEP 20 1982 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 2 2 | | | |
|---|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn K. CLEMONS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 11 82 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 8 1903 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING CARE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Baltimore County, Md. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Landon | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kackley Lucy Light | | 13e. STREET ADDRESS 1301 Mimosa Lane 20904 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Thomas L. Clemons-son-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic cancer of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-10</u> , 19 <u>82</u> , to <u>9-11</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9-11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Margaret S. Choa</u> | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED 9-11-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET S. CHOA | | | | 22e. ADDRESS 1111 Spring St Silver Spring Md 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-15-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar, 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B showing any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 2 3 | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN VAN DEUSEN CLUM | | | | | | 2a. DATE OF DEATH MONTH 9 DAY 6 YEAR 82 | | | | 2b. HOUR 1:15 A | | | |
| 3. SEX FE | | 4. RACE White | | 5. DATE OF BIRTH MONTH 6 DAY 2 YEAR 1894 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 88 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10216 Kensington Parkway | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Montgomery County Refuse | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10216 Kensington Parkway | | Zip: 20894 | | | |
| 14. FATHER'S NAME FIRST Cornelius MIDDLE W. LAST Clum | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE G. LAST Herring | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-12-1461 | | 17. INFORMANT ADDRESS Bertha Clum, Sister, Same as item #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 3429 DUE TO, OR AS A CONSEQUENCE OF (b) Left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/28/82 7/29/82 1972 | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 77 to Sept 6 19 82 that (I) (we) lost saw the deceased alive on Sept 5 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE John E. Everett | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. EVERETT | | | | 22e. ADDRESS 9400 CONN. AVE. KENSINGTON, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Sept. 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|--|----------------------------------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MACYE B. COHEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 7, 1982 | | | | | 2b. HOUR 6 ⁰⁰ p.m. |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 7, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY Souvenirs | | |
| 13a. STATE Maryland | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Sil. Spg. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1401 Blair Mill Road | | 20910 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Cohen | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Dennison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 578-46-6633 | | 17. INFORMANT ADDRESS Silver Spring, Md. Lillian P. Cohen; 1401 Blair Mill Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardio & cerebrovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 + months</u> <u>1 year</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>April 9-7</u> 19 <u>76</u> to <u>9-7</u> 19 <u>82</u> , that (I) (the) last of the deceased alive on <u>9-7</u> 19 <u>82</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated (I) (we) (over) (to) (at) (in) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Jason Geiger</u> DEGREE JASON GEIGER, M.D. | | | | | 22c. DATE SIGNED 9-7-82 | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER, M.D. | | | | | 22f. ADDRESS 8830 Cameron Street; Silver Spring, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn. Falls Church, Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE 20910 | | | | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE <u>Jean J. Connel</u> | | | |

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NOTED

Handwritten notes and markings on the right side of the page, including a large '2' and various scribbles.

Handwritten text line in the middle of the page.

Handwritten text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 2 5 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST VITO COLUCCI | | 2a. DATE OF DEATH | | MONTH DAY YEAR September 3 1982 | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH | | 2b. HOUR 11:25 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1904 Plyers Mill Road | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MARC COLUCCI | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lomoro GIACOMA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-61-9240 | |
| 17. INFORMANT ADDRESS Angela Colucci (Wife) Santa Ana Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Docuhte release, Cirrhosis of the liver, Arterial Hypertension.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1978 to Sept 3, 1982, that (I) (we) lost saw the deceased alive on Sept 2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hugo G. Graziani | | DEGREE MD | | 22c. DATE SIGNED Sept 4, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGO G. GRAZIANI | | 22e. ADDRESS 717 PERSHING Drive SILVER SPRING Md 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIAL) | | 23b. DATE 9/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Maryland | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H.Ave.S.S.Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 2 6

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Ruby Gladys Condon | | | 9-22-82 | | | 8:40/A | | | M | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Female | | | Caucasian | | | March 19, 1902 | | | 80 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| North Carolina | | | United States | | | Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | University Nursing Home | | | Homemaker | | | Own Home | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | | Gaithersburg | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. Big Acre Square | | | | | |
| FIRST MIDDLE LAST Rufus Jenkins | | | FIRST MIDDLE LAST Leora unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 243-08-7108 | | | Robert B. Nicklow same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diarrhea, Organic Brain Syndrome</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>82</u> to <u>9/22</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>RD Benack</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-22-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond T. Benack M.D. | | | | | | 22e. ADDRESS 4115 Colie Dr., Wheaton, Md. 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 24, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Ahoskie Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ahoskie North Carolina | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | |

BP

9-10-19

Dear Sir,
I have the pleasure to inform you that
the same has been forwarded to you
by the same.

Very truly yours,
J. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 2 7 | |
|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ERNEST MIDDLE GILDERROY LAST COOK, JR. | | 2a. DATE OF DEATH MONTH DAY YEAR 9-13-82 7:30 A.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 17, 1901 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest G. Cook Sr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora L. Stephens | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Director of Virginia | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 229 20 9154 | | 17. INFORMANT ADDRESS 6702 Thrasher Way Mechanicsville, Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 2500 DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 YEARS 4 YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Peripheral arterial insufficiency | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 30, 19 82, to SEPT 13, 19 82, that (we) lost saw the deceased alive on Sept 1, 19 82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 21. SIGNATURE Martin C. Sargel | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SARGEL | | 22e. ADDRESS 3720 FARRAGUT AVE KENNINGTON MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem. | |
| 24. FUNERAL DIRECTOR NAME Robert J. Hazelgrove | | ADDRESS Woody Funeral Home Richmond, Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Henrico Va. | |
| 25a. DATE REC'D BY REGISTRAR 17 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 2 8

REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Curtis Cook | | | 2a. DATE OF DEATH MONTH DAY YEAR September 5, 1982 | | | 2b. HOUR 12 45 AM | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS 12 45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) 1101 Second Ave, Silver Spring, MD | | | 12a. USUAL OCCUPATION (ADMINISTRATIVE OR PROFESSIONAL) Assistant | | 12b. KIND OF BUSINESS OR INDUSTRY Pentagon | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5403 Bradley Blvd. (20814) | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William E. Cook | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WWI | | 17 INFORMANT ADDRESS Laurel D. Cook, Wife, Same as item #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary artery disease, arterial insufficiency leg. | | | | | | | | | |
| 19a. DATE OF OPERATION Aug 28, 1982 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Doc. | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) we (hospital) attended the deceased from Aug 28, 1982 to Sept. 5, 1982 , that (I) we lost saw the deceased alive on Aug 28, 1982 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Edward W. Nicklas M.D. | | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. NICKLAS | | | | | 22e. ADDRESS 4830 V St. N.W. Wash. D.C. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | |
| 24 FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes, P.A., Bethesda, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 2 | 2 | 4 | 0 | 2 | 9 | |
|--|--|--|--|--|---|---|--|--|--|--|---|---|-----------------------------------|---|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JERRALD THRESHER COWELL | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29 1982 | | | | 2b. HOUR 1:10 a.m. | | | |
| 3. SEX MALE | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 27 1930 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. IF UNDER 24 HRS HOURS MIN. 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI | | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MARYLAND | | | | | | | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN GAITHERSBURG | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8103 FALLOW DRIVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACK VERNON COWELL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN RUTH THRESHER | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1968 | | | 17. INFORMANT MADELEINE COWELL | | | ADDRESS 8103 FALLOW DRIVE, | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) GASTRIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 20 , 19 82 , to SEPTEMBER 29 , 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Marion R. McMillan</i> | | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 29 Sept 82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARION R. MCMILLAN, LT, MC, USNR | | | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Oct. 1, '82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arl. Virginia | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Orsabel Sandison</i> Gartner Sandison F.H. | | | | | | 316 E. Diamond Ave., Gaithersburg, Md. 20877 | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 0 3 0 | |
|---|--|--|--|--|--|--|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Walker COX | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 7 82 | | 2b. HOUR 11:35 AM | | | |
| 3. SEX MALE | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR 3 11 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? AMERICAN | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Takoma Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR TRADING LIFE) Motorman Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Capital Transit | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Takoma Park | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herbert Cox | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Timberlake | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT ADDRESS Charles F. Cox Pensacola, Fla. 32503 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Post Operative Condition - Abdominal Aortic Aneurysm Repair | | | | | | | | | | | |
| 9a. DATE OF OPERATION 9/7/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Repair of Abdominal Aortic Aneurysm | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 3 , 19 82 , to Sept 7 , 19 82 , that (I) (we) last saw the deceased alive on Sept. 7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Phillip W. Roth MD | | | | DEGREE | | | | 22c. DATE SIGNED 9/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip W. Roth MD | | | | 22e. ADDRESS Suite 240 818 18th St. NW Washington DC 20006 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md. | | 25a. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | | | P.O. Box 7428 Sil. Spr., Md. | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | SEP 15 1982 | | | |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7 2 2 4 0 3 1 | | | | |
|--|--|--|--|--|--|--|--------|--|------|---|----------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST | | MIDDLE | | LAST | | 2b. HOUR | | | |
| Katherine N. CRAIG | | | | | | | | | | | 11 AM | | | |
| 3 SEX | | | | | 4 RACE | | | | | 5 DATE OF BIRTH | | | | |
| FEMALE | | | | | CAUCASIAN | | | | | JULY 28, 1891 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8 AGE (IN YEARS LAST BIRTHDAY) | | | | |
| NEW YORK | | | | | U.S.A. | | | | | 91 YRS. | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | |
| SILVER SPRING | | | | | CIRCLE MANOR NURSING HOME | | | | | TELEPHONE EMPLOYEE | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | 13a. STREET ADDRESS | | | | | 13b. CITY OR TOWN | | | | |
| N.Y. TELE CO. | | | | | 12104 FLINT LANE | | | | | 20715 | | | | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | |
| FIRST | | | | | LAST | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| LUISS | | | | | DURRENBAC | | | | | 108-22-5785 | | | | |
| 17 INFORMANT | | | | | ADDRESS | | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | |
| DOROTHY PAGE | | | | | SAME AS 13 DAUGHTER | | | | | Cardio-vascular Arrest | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | CITY OR TOWN | | | | |
| | | | | | | | | | | COUNTY | | | | |
| | | | | | | | | | | STATE | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from March 19 78 to September 7 19 82, that (i) (we) lost saw the deceased alive on about 10/10/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | | | | |
| CITY OR TOWN | | | | | | | | | | | | | | |
| COUNTY | | | | | | | | | | | | | | |
| STATE | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | | | | | |
| NAME | | | | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| FOR Items 18c & 19a&b | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | |
| 1. STATE REGISTRAR | | | | | Firm 573 11-26-82 cn | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| James Francis Creed-Detorie | | | | | September 12, 1982 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Male | | | | | White | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR | | | | | YRS. MONTHS DAYS HOURS MIN. | | | | |
| April 25 1951 | | | | | 31 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| VIRGINIA | | | | | U.S.A. | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Bethesda | | | | | Clinical Center, NIH, Bethesda, Md | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| TEACHER | | | | | SCHOOL | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | |
| Virginia | | | | | ARLINGTON | | | | |
| 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| Arlington | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| FRANCIS J. DETORIE | | | | | DOROTHY - DAVIS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| NO | | | | | 224-76-6185 | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Mrs. Carol Creed-Detorie, wife, patient | | | | | same as | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Adult respiratory distress syndrome | | | | | | | | | |
| 2050 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Chronic graft versus host disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ACUTE MYELOGENOUS LEUKEMIA | | | | | | | | | |
| 7 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 8-24-82 | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| Pericardial Tamponade | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (X) this hospital attended the deceased from August 21, 1982, to September 12, 1982, that (X) (we) lost saw the deceased alive on September 12, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (not) view the body after death. | | | | | | | | | |
| 22. SIGNATURE | | | | | | | | | |
| DEGREE | | | | | | | | | |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | |
| 72. DATE SIGNED | | | | | | | | | |
| 9/13/82 | | | | | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| J. N. Shelhamer | | | | | | | | | |
| 23b. ADDRESS | | | | | | | | | |
| National Institutes of Health | | | | | | | | | |
| Clinical Center, Bethesda, Md 20205 | | | | | | | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| BURIAL | | | | | | | | | |
| 23d. DATE | | | | | | | | | |
| SEPT. 16, 1982 | | | | | | | | | |
| 23e. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| FAIRFAX MEMORIAL PARK | | | | | | | | | |
| 23f. LOCATION | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | |
| FAIRFAX FAIRFAX CO. VIRGINIA | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | |
| CHAMBERS FUNERAL HOME SILVER SPRING, MD. | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| SEP 17 1982 | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 3 3 | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Martha L. Cross | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 82 | | | | 2b. HOUR 2:48 AM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS 11322 Schuykill Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Johnston | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Robinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-0491 | | 17. INFORMANT ADDRESS Pamela Cross (Daughter) same as #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BREAST CARCINOMA, WIDELY METASTATIC</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>78</u> , to <u>SEPT 17</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>SEPT 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Eugene P. Flannery, MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/17/82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY | | | | | | 22e. ADDRESS 18111 PRINCE PHILIP DR - OLNEY, MD - 20832 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | | | 24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850 | | 24c. DATE REC'D. BY REGISTRAR SEP 22 1982 | | | | | |

PROCTER

Wm. A.



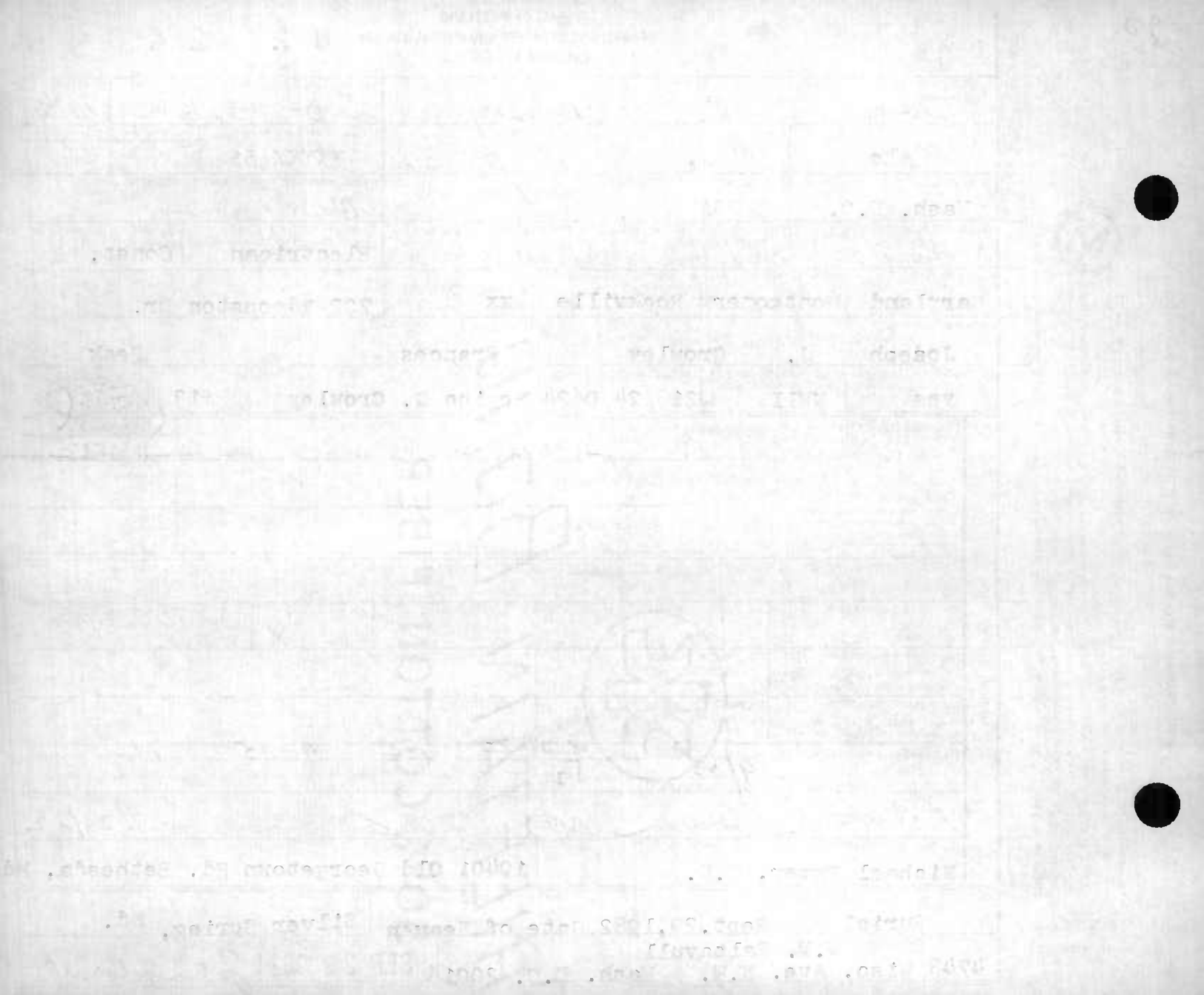
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 0 3 4 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Thomas B. CROWLEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 25, 1982 | | | | 2b. HOUR 10 ⁴⁵ M | | | |
| 3. SEX Male | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 10 30 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) XXX 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY Const. | | | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Crowley | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Peak | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT Regina G. Crowley | | | | ADDRESS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung carcinoma 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-21-82, 19 82, to 9-25, 19 82, that (I) (we) lost saw the deceased alive on 9/25, 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Michael Emmer MD | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/25/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Emmer, M.D. | | | | | | 22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 29, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. Taltavull 4748 Wisc. Ave. N.W. Wash. D.C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 3 5 | | | | | | | | | |
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| FOR 1. STATE REGISTRAR | | | REG. NO. | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST William | | | MIDDLE F. | | | LAST Dahl | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 21 82 | | | 2b. HOUR 3:28 AM | | | | |
| 3. SEX Male | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 14 1884 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | 8. IF UNDER 24 HRS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | | 12b. KIND OF BUSINESS OR INDUSTRY G.P.O. | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 105 Hill Top Road 20910 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Dahl | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Brunswick | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-46-4297 | | | 17. INFORMANT Agnes F. Dahl | | | ADDRESS Wife Same as 13 | | | | | | | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Blindness - Transient ischemic attacks - Urinary tract infection</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/15</u> 19 <u>74</u> , to <u>9/21</u> 19 <u>82</u> , that (1) (we) lost <u>8/25</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>George S. Kenton MD</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/21/82 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON | | | | | | 22e. ADDRESS 10620 GEORGIA AVE SILVER SPRG, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sep. 23, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u> | | | | | | | | | | |
| 500 University Blvd. W. Silver Spring, Md. | | | | | | | | | | | | | | | | | | | |

STATE OF HAWAII
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24036

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|---------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNA | | MIDDLE A. | | LAST DALY | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 16 YEAR 1982 | | 2b. HOUR 849 | |
| 3. SEX Female | 4. RACE CAUC | 5. DATE OF BIRTH MONTH 5 DAY 26 YEAR 92 | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 16 YEAR 1982 | | 2d. HOUR 849 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE MD | | 13b. COUNTY MONT GOMERY | 13c. CITY OR TOWN POTOMAC | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 10609 BELFAST PI. 20854 | | | | |
| 14. FATHER'S NAME FIRST George MIDDLE Wm. LAST Glover | | | | 15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE LAST Kane | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 071-30-5228 | | 17. INFORMANT ADDRESS Marie D. Porreco same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 10-20 YRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? - | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 PM 9 16 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) FOUND IN BED | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION STREET 10609 BELFAST PI. CITY OR TOWN POTOMAC COUNTY MONTGOMERY STATE MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayle | | TITLE (SPECIFY) DEPT | | MEDICAL EXAMINER | | DATE SIGNED 9/16/82 20814 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE | | ADDRESS 8200 Wisconsin Ave BETHESDA MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | 23d. LOCATION CITY OR TOWN Greenwich COUNTY Connecticut STATE | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 REGISTRAR'S SIGNATURE John J. Canfield | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

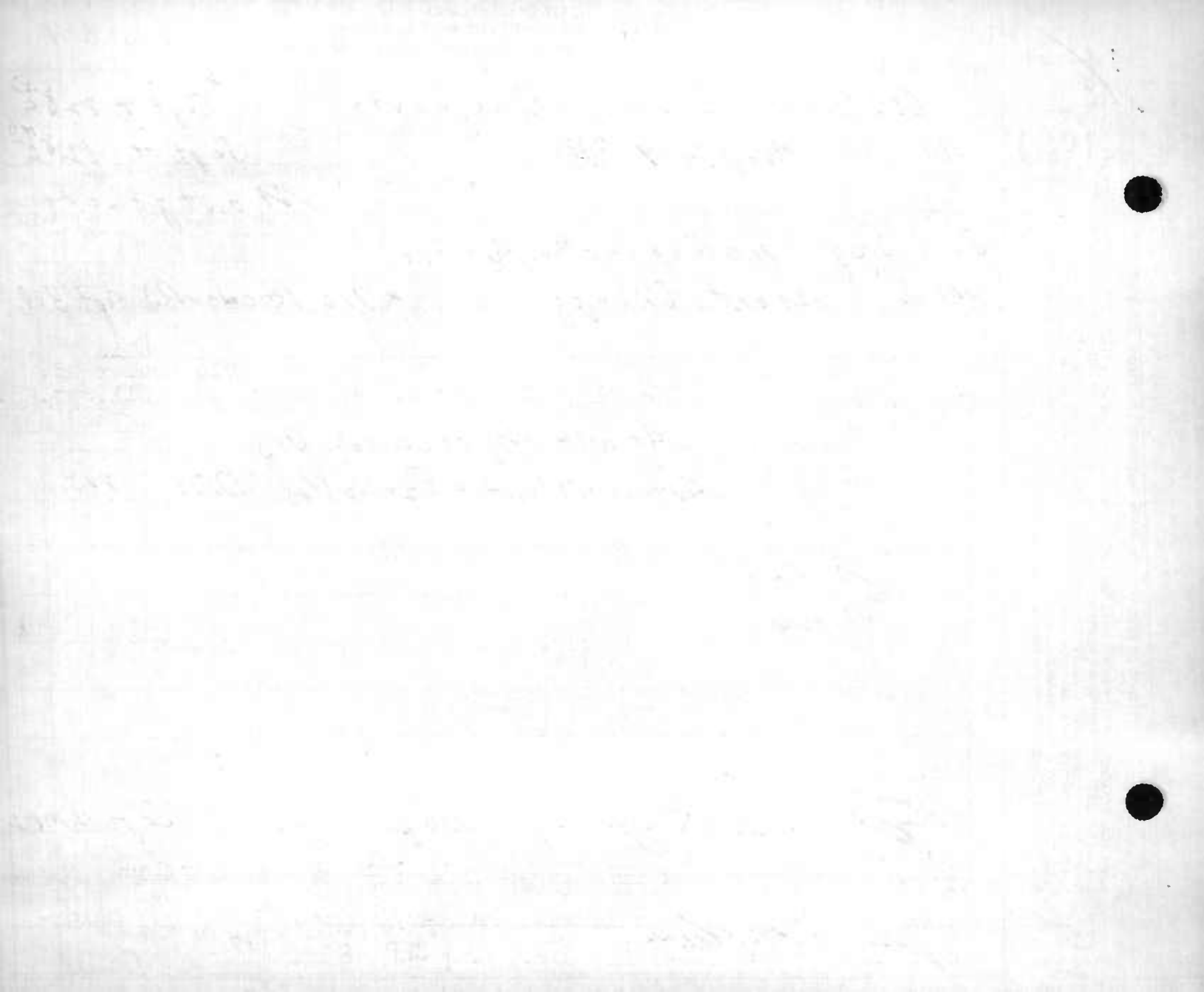
DHMH-17
(VR A15 ME (5))
15M2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 AE (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 | 24037 |
|--|------------------|---|-----------------------------|---|--|--|--|---|--|---|-------|
| 1. DECEASED NAME (TYPE OR PRINT) William Clarence Daugherty | | | | | | | | | | 2a. DATE KNOWN OF DEATH Sept. 4, 1982 | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH May 29, 1929 | 6. AGE (IN YEARS) 53 | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7b. DATE PRONOUNCED DEAD Sept 4, 1982 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 10. CITY OR TOWN OF DEATH Sil. Spr. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 710 Roeder Rd, Apt. 300 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Sil Spr | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 710 Roeder Rd Apt 300 | | 20910 | |
| 14. FATHER'S NAME William J. Daugherty | | | | 15. MOTHER'S MAIDEN NAME Edith Olin | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 268-01-3662 | |
| 17. INFORMANT Ella K. Daugherty | | | | ADDRESS #300, Sil. Spr. Md. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic Cardio Vas. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) DME | | DATE Sept. 4, 1982 | | MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | ADDRESS Silver Spring, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lulu Falls Cemetery | | 23d. LOCATION CITY OR TOWN Kingsville COUNTY Ohio STATE | | | | | |
| 24. FUNERAL DIRECTOR'S NAME Warner E. Pumphrey, Inc. | | ADDRESS Sil. Spr., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1982 | | 25b. REGISTRAR'S SIGNATURE John S. Rogers | | | | | |

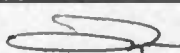


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 3 8 | | | |
|---|--|--|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charles Alfred Davis, JR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-11-82 | | 2b. HOUR 7:45 M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 11, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Davis Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie A. Davis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 1629 | |
| 17. INFORMANT ADDRESS Rasetta Addison (sister) Same AS #13 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably Cardiacpulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probably Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probably obstructive Bile duct disease</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1629</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> , 19 <u>9/11/82</u> , to <u>9/11/82</u> , 19 <u>9/11/82</u> , that (I) (we) lost saw the deceased alive on <u>9/11/82</u> , 19 <u>9/11/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE MD | | 22c. DATE SIGNED 9/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKAGUL MD | | | | 22e. ADDRESS 7425 ARLINGTON RD, BETHESDA, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY Ash Mem. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montg Md. | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | 24b. ADDRESS 246 N. WASH. ROCKVILLE, MD. | | 25. DATE REC'D. BY REGISTRAR SEP 16 1982 | |
| 25. REGISTRAR'S SIGNATURE P. J. Carver | | | | | | | |

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all things, things, things.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon parts. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 3 9 | |
|--|--|--|------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | 2b. HOUR |
| Verda M. Davis | | | | September 2, 1982 | 2:10 PM |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) |
| FEMALE | | WHITE | MAY 17, 1890 | | 92 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| W. Va. | | U.S.A. | | Montgomery MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Takoma Park | | Sligo Gardens Nursing Home | | RETIRED | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. INSIDE CITY LIMITS? | |
| NURSE | | 6223 60th PL. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STATE | | 13c. CITY OR TOWN | | 14. FATHER'S NAME | |
| MARYLAND | | RIVERDALE | | JOHN | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| WARNER | | THEOBE | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 2 13-42-8178 | | PT. chart | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | Sudden |
| IMMEDIATE CAUSE (a) Cardiac arrest secondary to arrhythmia | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Atrial fibrillation | | | | | Unknown |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) Arteriosclerotic cardiovascular disease | | | | | Unknown |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 27, 19 63, to Sept. 2, 19 82, that (I) (we) lost saw the deceased alive on Sept. 2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| Carl J. Houmann | | | | 9-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Carl J. Houmann, M. D. | | | | 4404 Queensbury Road, Riverdale, Md. 20737 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/6/1982 | | Washington National Cemetery | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| Takoma Park | | 25th | | SEP 7 1982 | |

DAVID

WILL

RECEIVED

FEMALE

W. W.

U.S.A

WHITE

MAY

1910

92

✓

JOHN

NO

213018

PT. 2.11

WINTER THREE

STANDARD

MARSHALL ISLANDS

✓

1910

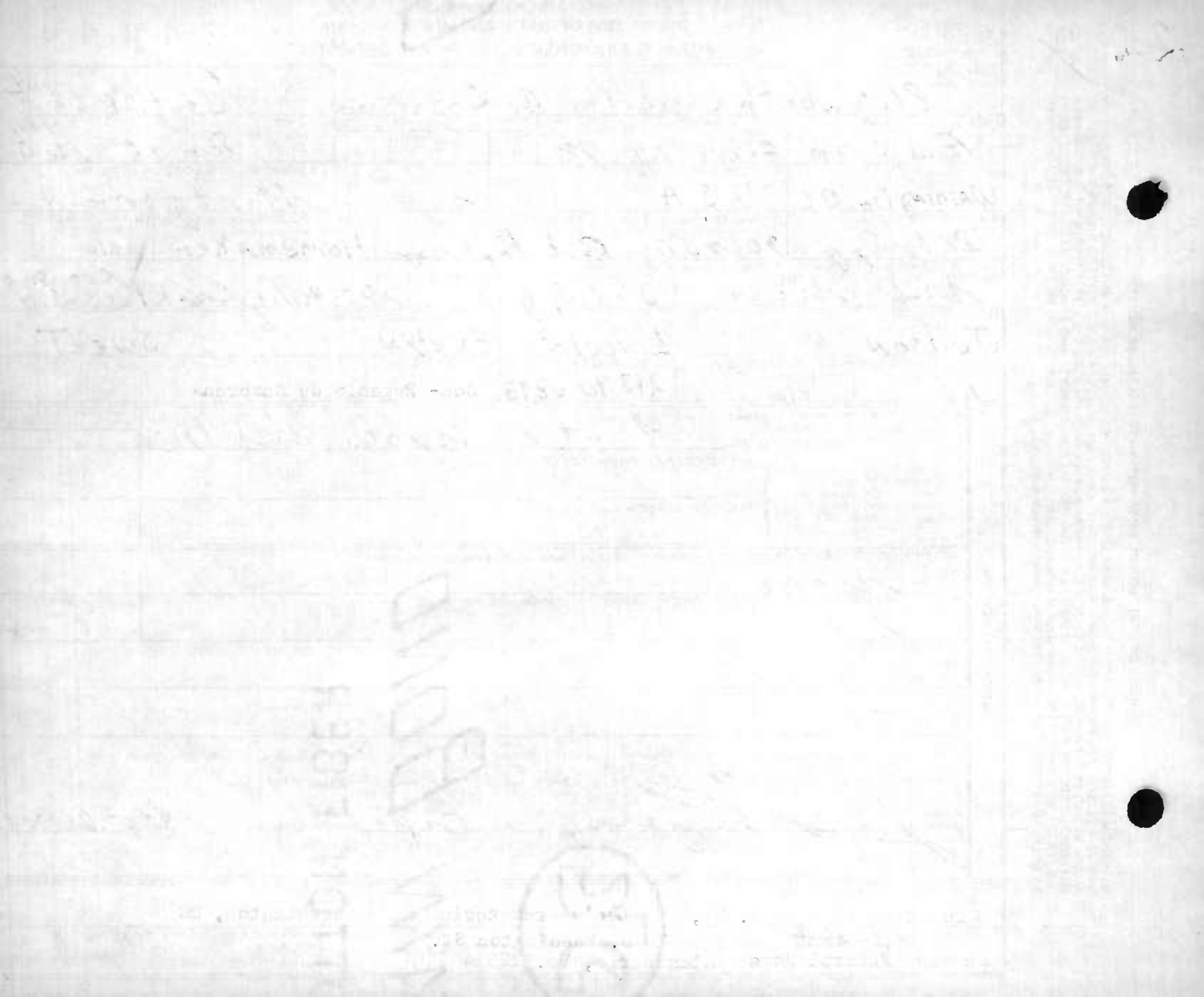
RECEIVED

NURSE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24040 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth Lincoln de Anzorena</i> | | | | | | 2a. DATE KNOWN OF DEATH <i>Sept. 26, 1982</i> | | 2b. HOUR <i>8:45</i> | | 2c. MONTH <i>Sept</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>Feb 4, 1948</i> | | 6. AGE (IN YEA. S. LAST BIRTHDAY) <i>34 YRS.</i> | | 7. IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i> | | 7a. DATE PRONOUNCED DEAD <i>Sept 26, 1982</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i> | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Sil. Spg.</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9039 Sili Creek Parkway</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>n/a</i> | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Sil. Spg.</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>9039 Sili Creek Parkway</i> | | | |
| 14. FATHER'S NAME <i>Judson</i> | | | | 15. MOTHER'S MAIDEN NAME <i>Lincoln Evelyn Sweet</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>n/a</i> | | 17. INFORMANT <i>Son- Eugenio de Anzorena</i> | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291 Acute Myocardial Dis.</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | | | TITLE (SPECIFY) <i>Dep</i> | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | DATE SIGNED <i>Sept. 26, 1982</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>Sept. 27, 82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematorium</i> | | 23d. LOCATION CITY OR TOWN <i>Washington, DC</i> | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR NAME <i>Demaine Funeral Home</i> | | ADDRESS <i>520 S. Washington St. Alexandria, Va. 22314</i> | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 4 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|--|------------------------------------|---|---|---|--------------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Margaret Ladd Dearing | | | MONTH DAY YEAR 9/2 19 82 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD | | |
| Female | White | Jul. 7, 1903 | 79 YRS. | | | 9/2 19 82 | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| CONNECTICUT | | U.S.A. | | Montgomery County | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | 8815 Reading Road | | | NATIONAL GEO. SOCIETY | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | Silver Spring | YES <input type="checkbox"/> NO <input type="checkbox"/> | 8815 Reading Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| ARTHUR I. CALL | | | | MABEL W. SOULE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| NO | | 579-48-8204 | | ATTORNEY J. ROBERT CAREY | | 10111 COLESVILLE R SILVER SPRING, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>endometrial carcinoma.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | |
| None | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| None | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | None | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | | |
| | | Deputy | | | | 9/2/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | |
| John S. Rogers, M.D. | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| CREMATION | | 9/3/82 | METROPOLITAN CREMATORY | | ALEXANDRIA VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | SEP 8 1982 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 0 4 2 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Lulu Elizabeth Degel | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/29/82 | | 2b. HOUR 11 A M | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) 307 Claggett Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORKER OR AGENT OR WORKING (IFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 307 Claggett Drive 20851 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lewis Cooper | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Vail | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT Theodore W. Degel same as 13e | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH five hrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION / | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED / | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>81</u> , to <u>9/29</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frauke Westphal M D | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/29/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal | | | | 22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | 25. DATE RECEIVED BY REGISTRAR OCT 4 1982 | | 25. REGISTRAR'S SIGNATURE John J. Conner | | | |

MEDICAL CERTIFICATION

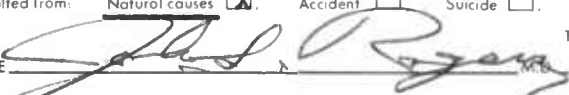

2
9

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24043 | |
|---|-------------------------|---|---|---|------------------|---|----------------------|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Slobodan Anta Dejanovich | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 9/13 1982 | | 2b. HOUR A. | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sep. 1, 1905 | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 9/13 1982 | 7d. HOUR 1:05 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Yugoslavia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8221 Flower Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAJOR OF THE ROYAL ARMY | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8221 Flower Avenue 20912 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ANTA DEJANOVICH | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEFIMIJA GARALEJIC | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 275-30-3575 | | 17. INFORMANT ADDRESS DANICA S. DEJANOVICH SAME AS 13 WIFE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER 1919 Seminary Road | | DATE SIGNED 9/13/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | ADDRESS Silver Spring, Montgomery, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C. | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |



Male

Age 1. 100

W

W

x

Lejovaria

A.

Blond

W

85

W

85

Montgomery County

Thomas Park

3211 Flower Avenue

Montgomery

Montgomery

3211 Flower Avenue

3211 Flower Avenue

Acute myocardial disease

Chronic myocardial disease.

Heart

None

None

None

x

Deputy

1919 Secretary Road

Silver Spring, Montgomery, Md.

John L. Rogers, M.D.

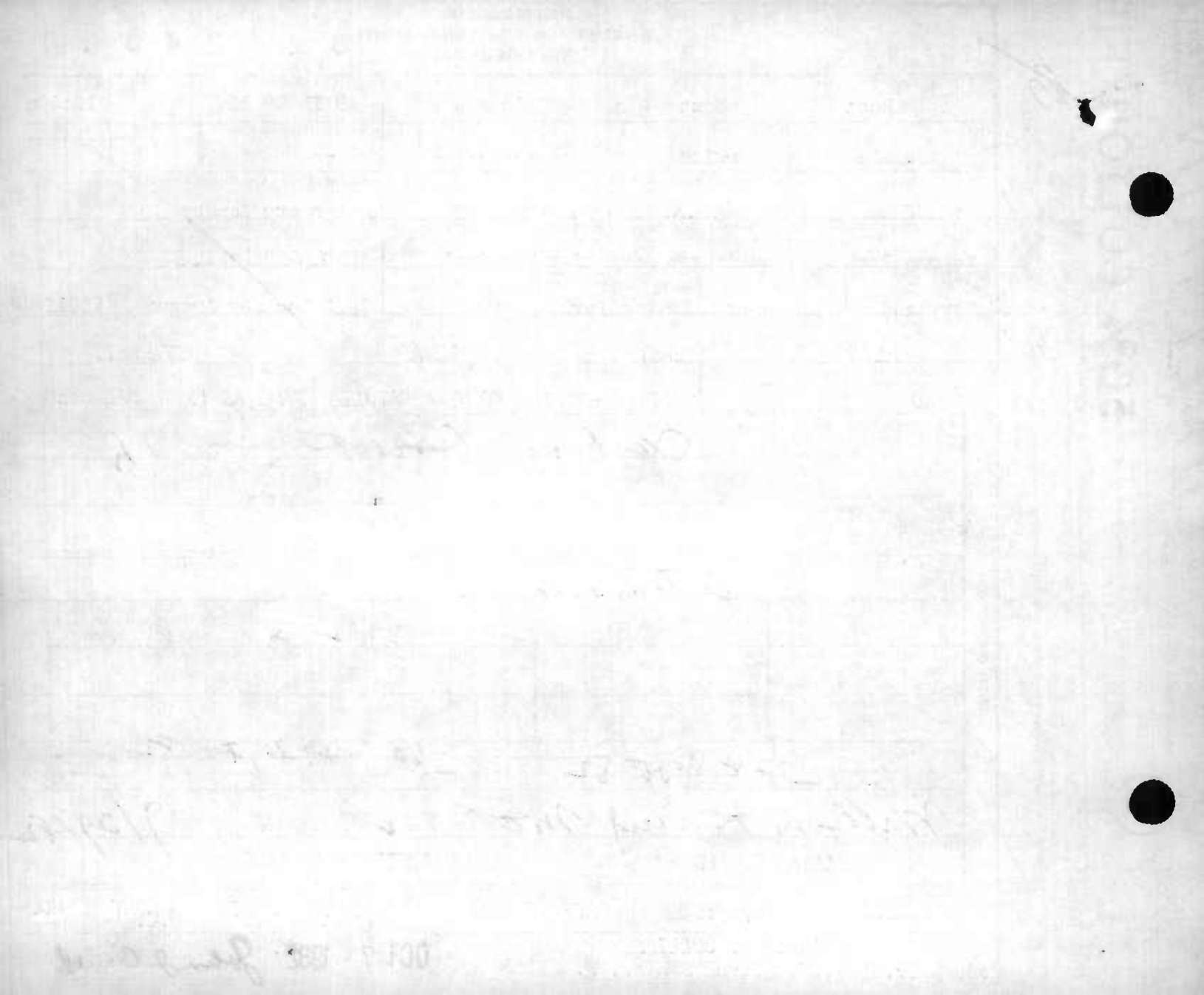
24702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, there was any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 4 4 REG. NO. | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|---------------------------|--|
| 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth East Deluca | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 XX 29 82 | | | | 2b. HOUR 10:40a | |
| 3 SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH MONTH DAY YEAR 01/16/1903 | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Pr. Geo. Takoma Park | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 7902 Lockney Avenue 20912 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALVA EAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA STARRETT | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 578-46-9977 | | | 17. INFORMANT ADDRESS ANTONINA NATOLI SAME AS 13 DAUGHTER | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1h | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerosis | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 Sept 82 to 29 Sept 82 , that (I) (we) last saw the deceased alive on 28 Sept 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE William D. Aud MD | | | | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/29/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. AUD | | | | | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 10/2/82 | | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | | 23d. LOCATION WASHINGTON D.C. | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | | | 24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 24c. DATE REC'D. BY REGISTRAR OCT 7 1982 | | | | | | |
| | | | | | | REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | |



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

8 2 2 4 0 4 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the remaining within 72 hours after death.

| | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) Lonie | | First M. DeMar | | Middle M. DeMar | | Last | | 2a. DATE OF DEATH 5 Sept. 8, 1982 | | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH Oct. 15, 1984 | | | 6. AGE (In years last birthday) 97 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 17604 Sequoia Drive | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 17604 Sequoia Drive | | | | |
| 14. FATHER'S NAME Wesley Chambers | | | | First Wesley Chambers | | Middle Wesley Chambers | | Last Wesley Chambers | | 15. MOTHER'S MAIDEN NAME Rosetta Riggs | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 217-30-0504 | | 17. INFORMANT Roger Garrison (Son) | | Address same As #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diffuse Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed YRS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/23, 1980 to September 7, 1982 , that (I) (we) last saw the deceased alive on 9/7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Robert Mittman | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 9/10/82 | | |
| 22d. PHYSICIAN'S NAME (Type) Robert Mittman MD | | 22e. ADDRESS 15 E Deer Park Dr Gaithersburg Md | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9-11-82 | | 23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Laytonsville, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR George R. Snowden | | | | 246 N. Washington St. Rockville, Md. 20850 | | 25a. REC'D BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE Jan G. Smith | | | | |

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Dr. Rogers, Notified & Approved

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 0 4 6 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Justine DeMattio | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 20, 1982 | | 2b. HOUR 10:20 AM | |
| 3. SEX female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR June 24, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. MONTHS DAYS | | IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18104 Hollingsworth Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Clifford Wallace | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecyle Tracy Perfect | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT 18104 Hollingsworth Drive James R. DeMattio, Rockville, Maryland 20855 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma @ breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertrophic cardiomyopathy 2° liver metastases. Also lung, bone, lymph node metastases.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>82</u> , to <u>20 Sept</u> 19 <u>82</u> , that (I) was last saw the deceased alive on <u>15 Sept</u> 19 <u>82</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Donald E. Dillon</u> MD | | | | | | 22c. DATE SIGNED Sept. 20, 1982 | | 22d. ADDRESS 18111 Prince Philip Dr., Olney Md. 20832 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE September 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY East Avenue Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE New Philadelphia, Ohio | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it and the official director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 4 0 4 7 REG. NO. | |
|--|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Irene</i> LAST <i>Dillon</i> | | 2a. DATE OF DEATH MONTH <i>9</i> DAY <i>5</i> YEAR <i>82</i> | | 2b. HOUR <i>7:40</i> M | |
| 3. SEX <i>FEMALE</i> | 4. RACE <i>CAUCASIAN</i> | 5. DATE OF BIRTH MONTH <i>DEC</i> DAY <i>4</i> YEAR <i>1907</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>74</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MASSACHUSETTS</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>MONTGOMERY</i> | 13c. CITY OR TOWN <i>SILVER SPRING</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST <i>CHARLES</i> MIDDLE <i></i> LAST <i>COOKE</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>HERMINIE</i> MIDDLE <i>DESCHENES</i> LAST <i></i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>244-32-2403</i> | | 17. INFORMANT ADDRESS <i>MORRIS M. DILLON SAME AS 13 HUSBAND</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory failure</i> <i>2001</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i> (c) <i>hypertension</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>lymphoma</i> | | | | | |
| 19a. DATE OF OPERATION <i>9/5</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>lymphoma</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2</i> P.M. <i>9</i> <i>5</i> <i>82</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET <i>2</i> CITY OR TOWN <i>9/5</i> COUNTY <i>2</i> STATE <i>MD.</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/5</i> 19 <i>82</i> , to <i>9/5</i> 19 <i>82</i> , that (I) (we) last saw the deceased prior to above (If we) did not visit with the body after death. | | | | | |
| 22b. SIGNATURE <i>Chas. N. Lewis MD</i> | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>9/5/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LEWIS DENNIS</i> | | 22e. ADDRESS <i>831 UNIV BLVD., SILVER SPRING, MARYLAND</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>9/8/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i> | |
| 23d. LOCATION (CITY OR TOWN) <i>SILVER SPRING</i> | | COUNTY <i>MONT</i> | | STATE <i>MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 4 3 REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| I. DECEASED NAME (TYPE OR PRINT) BILLY DOUGLAS DOBBINS | | | | 7a. DATE OF DEATH MONTH DAY YEAR SEPT. 7, 82 | | | | 7b. HOUR 1:57 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 5 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION OF DECEASED Supervisor Elec. Johns Hopkins Engineer | | 12b. KIND OF BUSINESS OR Lab. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 117 Piping Rock Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ross Mathis Dobbins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Lassetter | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11 454-26-5967 | | 17. INFORMANT ADDRESS Evelyn R. Dobbins-wife (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) septic shock 5660 DUE TO, OR AS A CONSEQUENCE OF (b) general septicemia 10 days DUE TO, OR AS A CONSEQUENCE OF (c) perirectal abscess 10 days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 78 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) renal failure, irreversible acidosis, P.T.C. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11125 Rockville Pike, Rockville, Md | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to Sept. 7 19 82 , that (I) (we) last saw the deceased alive on Sept 7 19 82 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. E. Ehermantraut MD | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilfred R. Ehermantraut | | | | 22e. ADDRESS 11125 Rockville Pike, Rockville, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 9-9-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC | | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home | | | | 11800 N.H. Avenue ADDRESS Sil. Spr. Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Joan J. Canineh | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 4 9 | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John H. Donohue | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 9, 1982 | | 2b. HOUR 2:22 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. of Defense | | | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Prince Georges Adelphi | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10115 Towhee Avenue, 20783 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph V. Donohue | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Green | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WWII 202 07 1936 | | 17. INFORMANT ADDRESS Ruth E. Donohue-wife-(same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetic. Brown - Leonard Syndrome</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1982</u> to <u>Sept 7, 1982</u> , that (I) (we) lost saw the deceased alive on <u>19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Seruch J. Kimble</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9-10-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch Kimble | | 22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-13-1982 | | 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park Falls Church Fairfax Va. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | ADDRESS Sil. Spr. Md. 20904 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | | | | | |
| REGISTRAR'S SIGNATURE <u>R. J. Quinn</u> | | | | | | | | | | | |

| | | | |
|-----------|---------------|-------------------|---------------------------|
| John | H. | Tomonua | Sept. 2, 1962 2:22 P. |
| Hale | White | Aug. 30, 1960 | 63 |
| Tomonua | USA | | Montgomery |
| John Jack | Washington | Advanced Hospital | Dept. of Defense |
| Harland | Prince George | Adelphi | 1015 Tucker Avenue, 20183 |
| John V. | Tomonua | Hale | Green |
| John | John | John | John |

(Auth. 7. Tomonua-412- (name as 125)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, or other traumatic event, the medical examiner will be notified about it.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 5 0 REG. NO. | | | | |
|--|--|--|--|---|--|--|--|-------------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR PM |
| 1. DECEASED NAME FIRST MIDDLE LAST Katherine A. Dougherty | | | | 9/16/82 | | | | 3 PM |
| 2. SEX FEMALE | | 3. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 10, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 9704 ARMISTEAD ROAD 20903 | | 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS LALLY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE LYNCH | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ROBERT E. DOUGHERTY | | ADDRESS SAME AS 13 HUSBAND | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC OVARIAN CARCINOMA 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JANUARY 1982, to SEPTEMBER 6, 1982, that (we) last saw the deceased alive on SEPTEMBER 6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE James G. Brown, M.D. | | | | 22c. DATE SIGNED 9/7/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Brown, M.D. | | |
| 22e. ADDRESS 6525 BELCREST RD. HYATTSVILLE, MD 20782 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 10 1982 John J. Smith | | | | |

Mr. E. J. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Folders may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.)

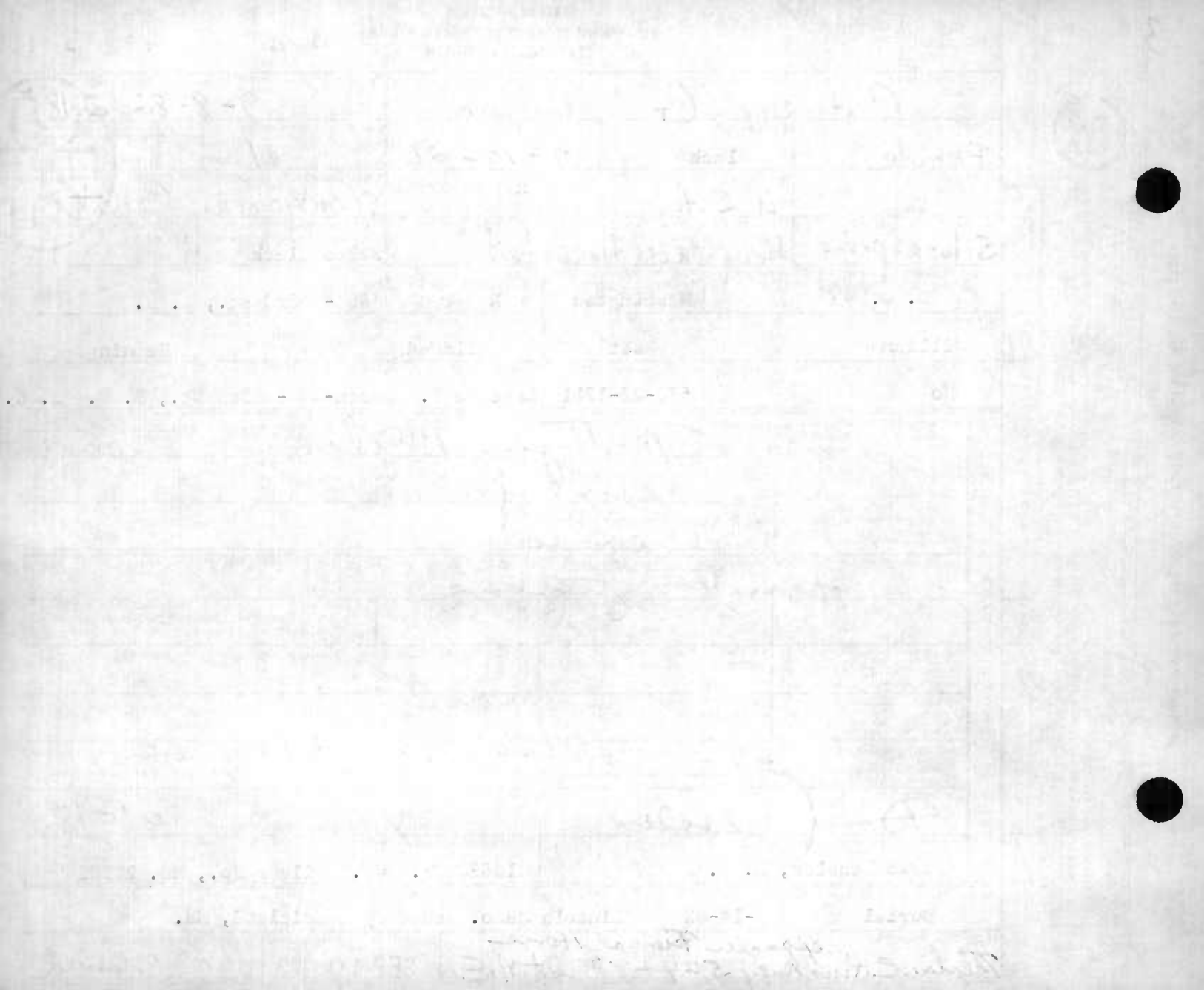
item 7a #G572 #0/4/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 5 1

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Catherine G. Dunson</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-8-82</i> | | 2b. HOUR <i>2:18 P</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>7-13-21</i> | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i> | | 7c. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i> | | 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Clerk</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>D. C.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Washington</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William West</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mildred Hennings</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>578-22-1711</i> | | 17. INFORMANT ADDRESS <i>Larence P. Dunson-46 - 53rd St., S. E. D. C.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c) are not to be used together.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>sepsis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 mos</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>thrombocytopenia</i> | | | | | |
| 19a. DATE OF OPERATION <i>8/20</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | |
| 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> , 19 <i>82</i> , to <i>9/8</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>9/7</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>David Kessler</i> | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>9/9/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David Kessler, M. D.</i> | | 22e. ADDRESS <i>10620 Ga. Ave. Silver Sp., Md. 20902</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9-14-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memo. Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Theodore C. Pinsky 524 - 8th St. N.E.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. G. G. G.</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

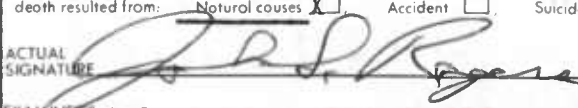

BP _____

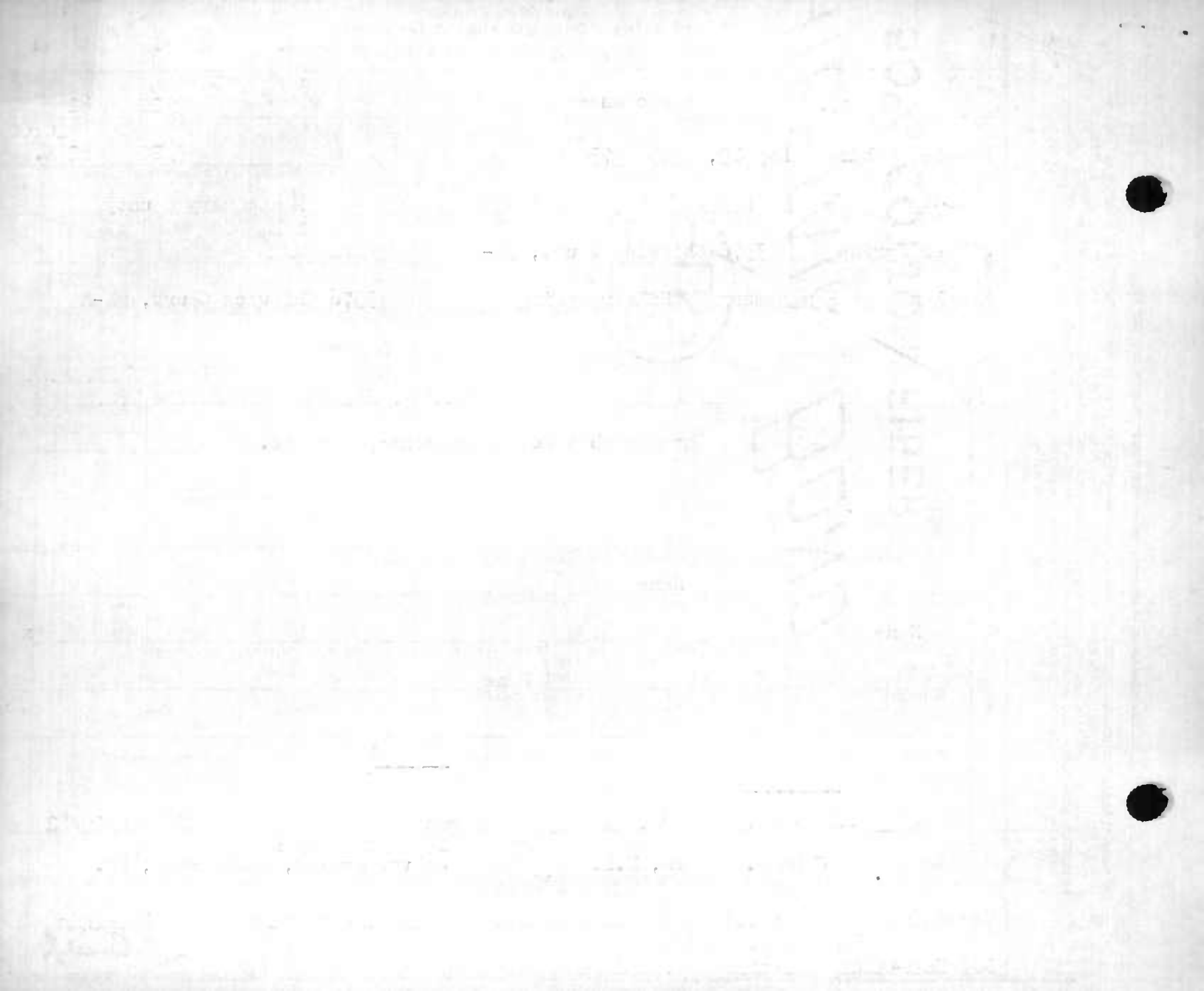
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Faye Rosecrance Eberth | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9/20 19 82 | | | 2b. HOUR 10:00 A. M. | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 19, 1909 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD 9/20 19 82 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3576 Chiswick Court, #1-A | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3576 Chiswick Court, #1-A 20906 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Nephew Robert W. Eberth ADDRESS 1825 T St., N.W. Washington D.C. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease.</u> 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy | | DATE SIGNED 9/20/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Gollins | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE  | | |
| 500 University Boulevard, W. Silver Spring, Md. | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, any injury, or other traumatic event, the medicolegal examiner should be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR Kathryn M. Eccles | | | | | 8 2 2 4 0 5 3 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Kathryn M. Eccles | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/5/82 | | | 2b. HOUR 11:40 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9815 Brixton Lane | |
| 4. FATHER'S NAME FIRST MIDDLE LAST Thomas Kiley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary Burke | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 217-42-2685 | | 17. INFORMANT ADDRESS Marie A. Eccles Same as Item # 13 | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2849 APLASTIC ANEMIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHOLECYSTITIS | | | | | | | | | |
| 19a. DATE OF OPERATION 8-4-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLECYSTITIS | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-3 , 19 82 , to 9-5 , 19 82 , that (I) (we) last saw the deceased alive on 9-5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard H. Pollen MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-6-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD H. POLLEN | | | | | 22e. ADDRESS 10000 Cornerstone Ave Kensington, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md. | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. | | | | | 25a. DATED AND SIGNED BY REGISTRAR SEP 14 1982 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

MEDICAL CERTIFICATION

100-42-2082

Mr. J. D. Jones

State

Female

NY

W. A.

New York

215 Madison Ave

Telephone

100-42-2082

Room

July

July

100-42-2082

Same as Item 13

100-42-2082

100-42-2082

100-42-2082

100-42-2082

100-42-2082

100-42-2082

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100-42-2082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 5 4
REG. NO.

| | | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mark Arnold Feldman | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 8, 1982 | | 2b. HOUR 12 20 AM | | | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 22, 1953 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 29 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN RESIDENTIAL FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) BOOKS | | 12b. KIND OF BUSINESS OR INDUSTRY ART SALES | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 733 SLIGO AVENUE, APARTMENT 210 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS FELDMAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAM DECHTER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 215-48-2299 | | 17. INFORMANT ADDRESS 802 GREGORIA DRIVE GERALD V. DECHTER, SILVER SPRING, MARYLAND | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio Pulmonary Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Massive Upper Intestine Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) diabetes, Arterio Sclerosis | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/24/82 P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/24/82 to 9/7/82 , that (I) (we) last saw the deceased alive on 9/7/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Tony P. KANNARKAT DEGREE MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/8/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tony P. KANNARKAT | | | | | | 22e. ADDRESS 8201 16th St Blair House Silver Spring MD 20910 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 9/9/1982 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN FALLS CHURCH, VIRGINIA | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | |
| 23e. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | | |



NOTION 12/11/11

WILLIAM
11/11/11
CD

11/11/11
11/11/11
11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 5 5 REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Samuel Fitzgerald | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 8, 1982 | | 2b. HOUR 3:20 P_M | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 11/11/1938 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dist. of Columbia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Transportation Sp. | | 12b. KIND OF BUSINESS OR INDUSTRY Grocery | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY Washington, DC 13c. CITY OR TOWN Washington, DC 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 404 Rittenhouse St., NW | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Charles Fitzgerald | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ann Maddox | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-50-8704 | | 17. INFORMANT ADDRESS Mrs. Martha Fitzgerald, wife, same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Left ventricular dysfunction IMMEDIATE CAUSE (a) 4241 DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) 1 year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 27 July 1982 to 8 September 1982 , that (X) (we) lost saw the deceased alive on 8 September 1982 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check box.) | | | | | | | |
| 22b. SIGNATURE Jeffrey E. Sell | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey E. Sell | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Natl. Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Serv. ADDRESS Wash., D.C. 7400 Georgia Ave. N.W. | | | | 25a. DATE REC'D. BY REGISTRAR SFP 17 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

BP

RECEIVED
JAN 10 1964

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

[illegible text]



100%
[illegible text]



[illegible signature or text]

#9/27/82 FilmG571 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 5 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NANCY Louise FITZPATRICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 82 | | | 2b. HOUR P M 10 P | | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 4 11 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Wheaton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David M. Tice | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Scott Apple | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-16-6167 | | | 17. INFORMANT ADDRESS Son James D. Fitzpatrick Baltimore, Md. 21217 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitochondrial Peroxisome 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ Hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/10/82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/3/82 19____, to 9/10/82 19____, that (I) (we) saw the deceased alive on 9/10/82 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (4-4) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE R Cioffi | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R Cioffi | | | 22e. ADDRESS 10620 Ga Ave S.S. Rd | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sep. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md. | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



Handwritten text at the top of the page, including the date "10/10/19" and the word "HAWAII".

Main body of handwritten text on lined paper, appearing as a list or series of notes.

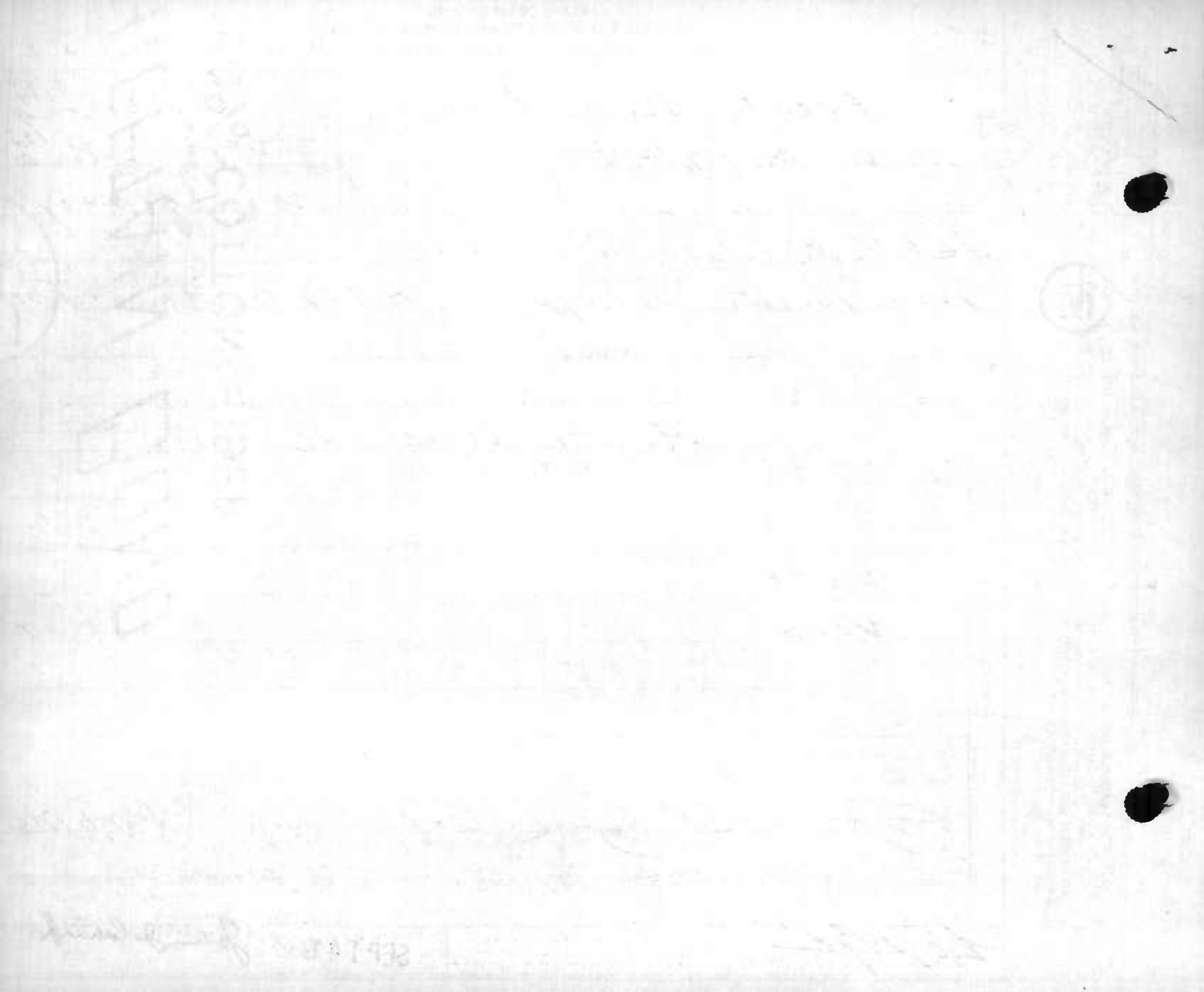
REG. NC

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-60. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PA-60. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF BURIAL OR CREMATION. **TO HEALTH OFFICIALS:** DIVISION OF VITAL RECORDS, 201 WM. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP_____

DHMH-17
(VR A15 ME (5))
15M 2/80



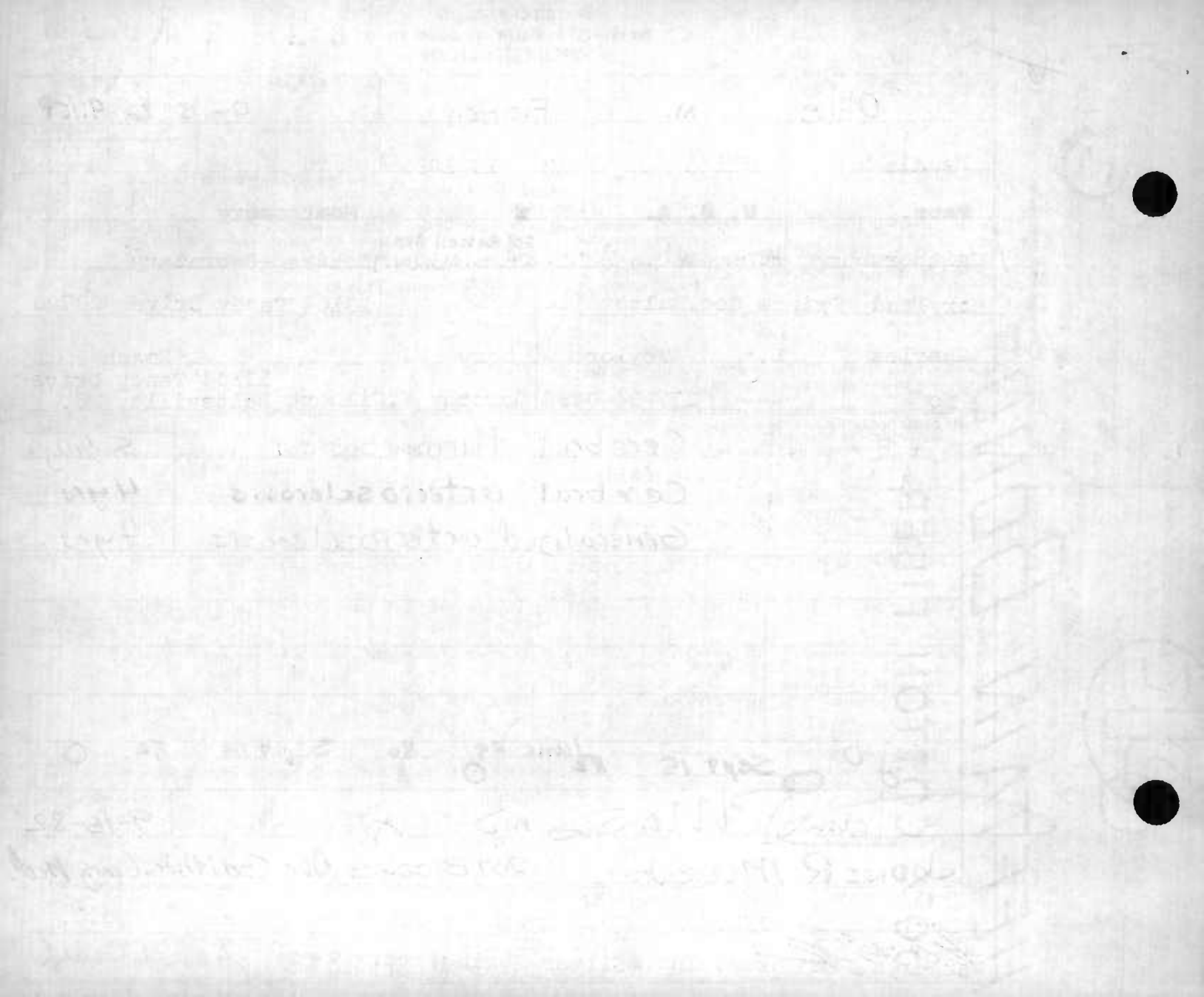
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 4 0 5 8
CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Olive M. Flouton | | MONTH DAY YEAR HOUR 9-15-82 9:15 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Female | White | MONTH DAY YEAR 12 15 1891 | 90 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Mass. | U. S. A. | | Montgomery MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Gaithersburg | Herman Wilson H.C. - 301 Russell Ave Gibbs, Md. 20871 | Retired-Secretary | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| Maryland | Prince Geo. | Beltsville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | 13e. STREET ADDRESS | |
| Charles L. Taylor | Mary Roach | 13104 Taney Drive 20705 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| No | 217-34-0468 | Dorothy F. Gilbert Beltsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4340 IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis | | | 4 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis | | | 4 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 25, 1980, to Sept 15, 1982, that (1) (we) last saw the deceased alive on Sept 15, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE James R. Moore Jr. MD | | 22c. DATE SIGNED 9-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| James R. Moore Jr. | | 207 Brookes Ave Gaithersburg Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 9/18/82 | Rock Creek Cemetery | Washington, D.C. |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Warner E. Pumphrey, Inc. | | SEP 23 1982 | John J. Conner |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 5 9 | | | |
|--|--|---|--|--|--|---|--|
| 1 - STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| ELIZABETH M. FORE | | | | SEPT 15 '82 4:15 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | NOV. 14, 1913 | | 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| WASH. D.C. | | U.S.A. | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| SILVER SPRING | | | | AND NRS. CHEV CHASE RET. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Sgt. PER. OFFICER | | | | U.S. SOU'T. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD. | | MONTG. | | BETHESDA | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (TYPE OR PRINT) | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| WILLIAM C. Mc LOWMAN | | ROSE WILLIAMSON | | 5802 RAMSGATE RD. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | 298-26-4039 | | HUSBAND - ALLEN W. FORE - SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA Lung 3 MONTHS | | | | | | | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, COLON 2 YEARS | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WREST | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 18 '82 Date of death | | | | | | | |
| and that (my) (our) opinion of death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| THOS G. WARD M.D. | | | | 9/15/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| THOS G. WARD | | | | 6116 ROBIN WOOD BETHESDA 20817 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | SEPT. 20, 1982 | | ROCK CREEK CEM. | | WASH. D.C. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| James P. B. W. | | SEP 20 1982 | | John J. C. W. | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 6 0 | | | |
|--|--|--|--|--|--|---|--|
| FOR 1. STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| MAYNE T FRENCH | | | | 9 16 82 1 35 A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Caucasian | | October 23, 1901 | | 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Virginia | | United States | | | | MONTGOMERY County, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | SUBURBAN Hospital | | Payroll Clerk | | N.I.H. | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | | | Montgomery | | Bethesda | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| William Swank | | | | Clara Myers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | 577-01-4141 | | Herman H. Swank, Brother, 11225 Waycross Way, Kensington, MD. 20895 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) 4360 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism 2 hrs | | | | | | | |
| (c) Prolonged immobility 2 years | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident 17 years | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10, 19 82, to 9/16, 19 82, that (I) (we) last saw the deceased alive on 9/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John O. Allin M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John O. Allin M.D. | | | | 22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Sept. 18, 1982 | | Ft. Lincoln Cemetery | | Brentwood Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| P.A., Bethesda, Maryland | | | | SEP 22 1982 | | John J. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16-50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 0 6 1 | | | |
|---|--|--|--|---|---|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | |
| REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL G. FRIEDLANDER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 82 | | | | | 2b. HOUR 1325 M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 21, 1903 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Rockville | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6121 Montross Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Gundersheimer | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Lump | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 577-03-6031 | | | 17. INFORMANT Philip P. Friedlander | | | ADDRESS Vienna, Va. 22108 104 Sanoey Cir. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METABOLIC ACIDOSIS 2762 DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) UNDETERMINED ETIOLOGY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Hours 24 Hours | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CONGESTIVE HEART FAILURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/7/82 to 9/8/82 , that (I) (we) last saw the deceased alive on 9/8/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE M.D. Patel | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 9/8/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL, M.D. | | | | | 22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wash., D.C. | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler Sons, Inc. 5130 Wise. Ave. N.W. Wash., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | |

2130 Waco, Ave. N.W. Wash., D.C.

Joseph Andrew, Inc.

James. Robert Jones. Vanna, D.C.

D. D. FATER, Inc. 1111 N. MONTGOMERY ST. CHICAGO, ILL.

4/8/52

CONGESTIVE HEART FAILURE

20 HOURS

20 HOURS

20 HOURS

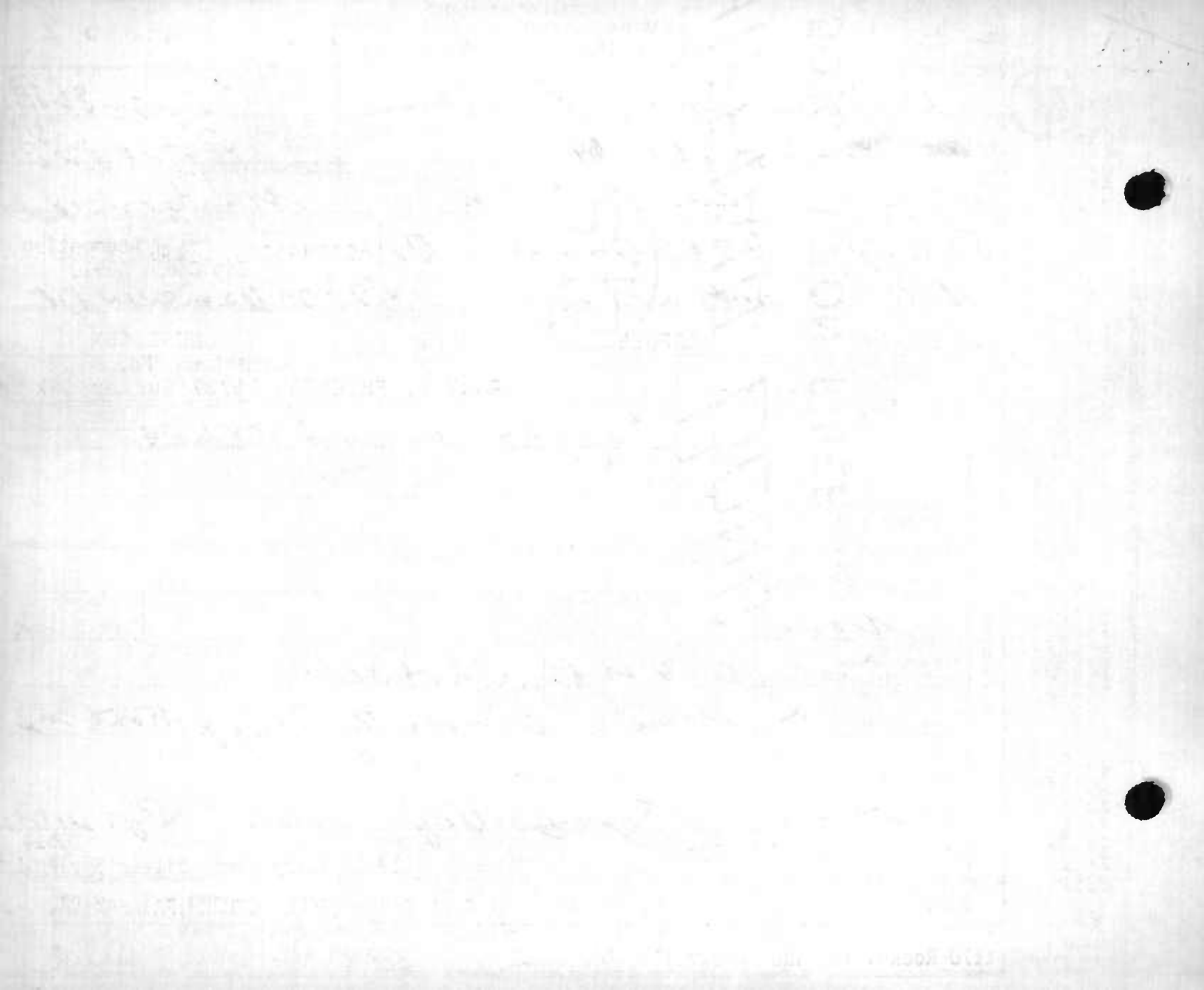
20 HOURS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHM-17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 24062 | |
|--|--|----------------------------|--|---|--|---|--|---|------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>William Samuel Friedman</i> | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <i>Sept 20 1982</i> | | 2b. MONTH DAY YEAR | | 2c. HOUR | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Sept 25 12 69</i> | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD <i>Sept 20 1982</i> | | 7d. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>St. L. Pp.</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2700 Drexel Dr</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Accountant (Ret)</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Accounting</i> | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN <i>St. L. Pp.</i> | | 13e. STREET ADDRESS <i>2700 Drexel Dr</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>SCHMEIL RAFUEL</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>JENNY NUSSBAUM</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>-----</i> | | 17. INFORMANT <i>GARY S. FRIEDMAN; 11737 Summer Oak Dr</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound of chest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Shot while</i> | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>Sept 20 1982</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Shot while</i> | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Drexel Dr. St. L. Pp. Mont. MD</i> | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dr. John Rogers</i> | | | | | | TITLE (SPECIFY) <i>M.D.</i> | | | MEDICAL EXAMINER <i>Dep</i> | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS <i>1919 Seminary Road; Silver Spring, Md</i> | | | DATE SIGNED <i>Sept 24 1982</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>Burial</i> | | | | 23b. DATE <i>9/22/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEMORIAL GARDEN; FALLS CHURCH; FAIRFAX; VA.</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 24 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Joan J. Connel</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on and

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 6 3 | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST WEBSTER R. Frye | | | | | | MONTH DAY YEAR Sept. 28, 1982 | | | | 12 40 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| M | | W | | MONTH DAY YEAR 8 12 77 | | 85 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Wash. D.C. | | USA | | | | Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | | | | | D.C. Fireman | | Retired | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| Md. | | | | | | Mont. | | S.S. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| William R Frye | | | | | | Margaret Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes WWI | | | | | | 579 01 5108 | | Madeline Frye (Wife) Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 4 days | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>82</u> , to <u>9/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Herman B. Segal MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herman B. Segal MD | | | | | | 22e. ADDRESS 5236 Park Ave Bethesda Md 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 9/30/82 | | Marshall Cemetery | | Marshall, Va. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hines/Rinaldi 11800 N.H.Ave. S.S.Md. | | | | | | SEP 30 1982 | | John J. Connel | | | | | |

BP

Received of Mr. [Name] the sum of [Amount] for [Purpose]

Caroline's [Name] [Address]

He was [Name] [Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, then indicate how and when the medical examiner was notified or consulted.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 6 4
REG. NO.

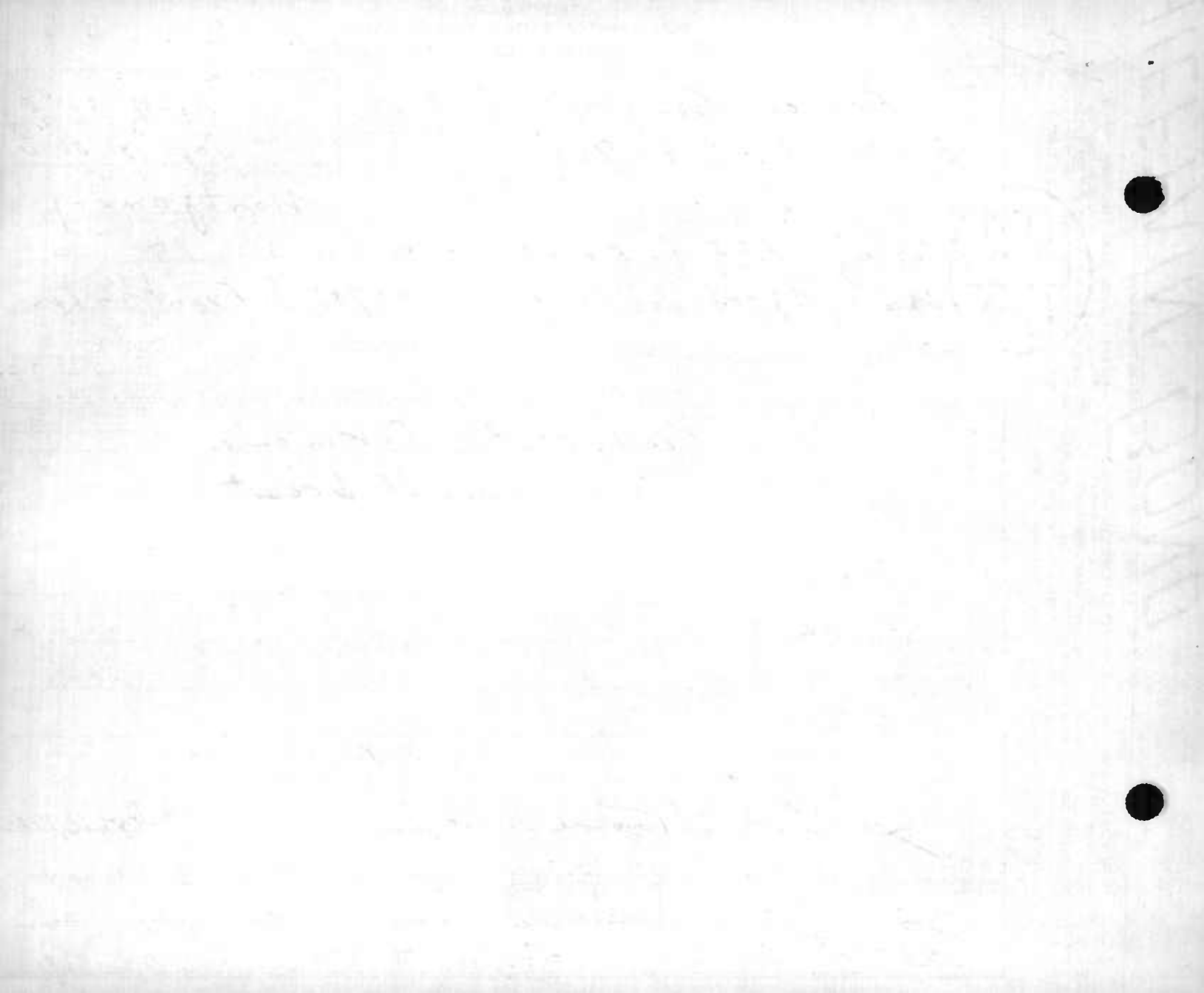
| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE C. GAUVREAU | | 2a. DATE OF DEATH MONTH DAY YEAR 9-10-82 | | 2b. HOUR 5⁰² P.M. | |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 2/29/12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN PRI. GEORGE HYATTSVILLE | | 13c. STREET ADDRESS 6700 BELCREST ROAD 20782 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY A. CUMBERLAND | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HUNT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES WW II | | 16b. SOCIAL SECURITY NO. 579-05-7872 | | 17. INFORMANT SON JOSEPH GAUVREAU ADDRESS 1127 FORBES BOULEVARD SEABROOK, MARYLAND 20706 | |
| 18. CAUSE OF DEATH (Enter only one cause per line. (a), (b), (c) optional.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial shock. DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) emphysema | | | | | |
| 19a. DATE OF OPERATION 9/14/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED emphysema | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/10/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) fall | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE SILVER SPRING, MARYLAND | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10/82 to 9/10/82 , that (I) (we) lost saw the deceased alive on 9/10/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a), (b), (c), and not view the body after death. | | | | | |
| 22b. SIGNATURE Lewis Dennis | | 22c. DATE SIGNED 9/10/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS DENNIS | |
| 22e. ADDRESS SILVER SPRING, MARYLAND | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | |
| 23b. DATE 9/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE Jan J. Conner | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 24065 | |
|--|------------------|---|---|--|--------------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frances Marguerite Gilbert | | | | | | 2a. DATE KNOWN OF DEATH Sept 17 1982 | | 2b. HOUR 11:00 | | 2c. DATE PRONOUNCED DEAD Sept 18 1982 | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH (MONTH DAY YEAR) Sept 2 1909 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | 10. CITY OR TOWN OF DEATH Sil. Sp. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 705 E. Franklin Ave. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | 10. CITY OR TOWN OF DEATH Sil. Sp. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 705 E. Franklin Ave. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | 13a. STREET ADDRESS 705 E. Franklin Ave. | | 13b. CITY OR TOWN Sil. Sp. | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 705 E. Franklin Ave. | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Unknown Young | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Elizabeth Buckley | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-70-9162 | | 17. INFORMANT Dr. Richard A. Gilbert | | 17b. ADDRESS 705 E. Franklin St. Sil. Sp., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | | | | | TITLE (SPECIFY) Medical Examiner | | DATE SIGNED Sept 18, 1982 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, D.M.E. | | | | | | ADDRESS Silver Spring, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY University Cemetery | | 23d. LOCATION CITY OR TOWN Charlottesville, Va. | | 23e. COUNTY Va. | | 23f. STATE | |
| 24. FUNERAL DIRECTOR (NAME) Warner E. Pumphrey, Inc. | | ADDRESS 8434 Ga. Ave. Sil. Sp., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#1, per call w/F.H. 9/22/82 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 6 6

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Orin</u> MIDDLE <u>Oran</u> LAST <u>Harold</u> <u>Goehring</u> | | | 2a. DATE OF DEATH MONTH <u>Sept</u> DAY <u>16</u> YEAR <u>1982</u> | | 2b. HOUR <u>11:07</u> P M | | | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>3</u> DAY <u>11</u> YEAR <u>1907</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Rockville</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Shady Grove Adventist Hospital</u> | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>mathematician</u> | |

| | | | | | | | | | | | | |
|---|--|--|----------------------------------|--|--|--|--|---|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u> | | | 13b. COUNTY <u>Montgomery</u> | | | 13c. CITY OR TOWN <u>Rockville</u> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>615 Crocus Drive 20850</u> | |
| 14. FATHER'S NAME FIRST <u>Walter</u> MIDDLE <u>M.E.</u> LAST <u>Goehring</u> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Ethel</u> MIDDLE <u>McClelland</u> LAST <u>McClelland</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>170 16 8014</u> | | 17. INFORMANT <u>Helen F. Goehring</u> ADDRESS <u>same as 13e</u> | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Biventricular Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Coronary Heart Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>1-2 years</u> | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>82</u> to <u>9/16</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/16</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Herman B Segal</u> DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/17/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Herman Segal</u> | | | | 22e. ADDRESS <u>5632 Shields Drive Bethesda, Maryland</u> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>9/20/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Wildwood Cemetery</u> | | 23d. LOCATION CITY OR TOWN <u>Salamanca</u> COUNTY <u>Cattaraugus</u> STATE <u>New York</u> | |
|--|--|-----------------------------|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland 20852</u> | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 21 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u> | |
|---|--|---|--|---|--|

| Date | | Description | | Amount | |
|------|--------|-------------|--|--------|--|
| 1917 | Jan 1 | Balance | | 100.00 | |
| 1917 | Jan 15 | Interest | | 5.00 | |
| 1917 | Feb 1 | Interest | | 5.00 | |
| 1917 | Feb 15 | Interest | | 5.00 | |
| 1917 | Mar 1 | Interest | | 5.00 | |
| 1917 | Mar 15 | Interest | | 5.00 | |
| 1917 | Apr 1 | Interest | | 5.00 | |
| 1917 | Apr 15 | Interest | | 5.00 | |
| 1917 | May 1 | Interest | | 5.00 | |
| 1917 | May 15 | Interest | | 5.00 | |
| 1917 | Jun 1 | Interest | | 5.00 | |
| 1917 | Jun 15 | Interest | | 5.00 | |
| 1917 | Jul 1 | Interest | | 5.00 | |
| 1917 | Jul 15 | Interest | | 5.00 | |
| 1917 | Aug 1 | Interest | | 5.00 | |
| 1917 | Aug 15 | Interest | | 5.00 | |
| 1917 | Sep 1 | Interest | | 5.00 | |
| 1917 | Sep 15 | Interest | | 5.00 | |
| 1917 | Oct 1 | Interest | | 5.00 | |
| 1917 | Oct 15 | Interest | | 5.00 | |
| 1917 | Nov 1 | Interest | | 5.00 | |
| 1917 | Nov 15 | Interest | | 5.00 | |
| 1917 | Dec 1 | Interest | | 5.00 | |
| 1917 | Dec 15 | Interest | | 5.00 | |
| 1917 | Total | | | 100.00 | |

| Date | | Description | | Amount | |
|------|--------|-------------|--|--------|--|
| 1917 | Jan 1 | Balance | | 100.00 | |
| 1917 | Jan 15 | Interest | | 5.00 | |
| 1917 | Feb 1 | Interest | | 5.00 | |
| 1917 | Feb 15 | Interest | | 5.00 | |
| 1917 | Mar 1 | Interest | | 5.00 | |
| 1917 | Mar 15 | Interest | | 5.00 | |
| 1917 | Apr 1 | Interest | | 5.00 | |
| 1917 | Apr 15 | Interest | | 5.00 | |
| 1917 | May 1 | Interest | | 5.00 | |
| 1917 | May 15 | Interest | | 5.00 | |
| 1917 | Jun 1 | Interest | | 5.00 | |
| 1917 | Jun 15 | Interest | | 5.00 | |
| 1917 | Jul 1 | Interest | | 5.00 | |
| 1917 | Jul 15 | Interest | | 5.00 | |
| 1917 | Aug 1 | Interest | | 5.00 | |
| 1917 | Aug 15 | Interest | | 5.00 | |
| 1917 | Sep 1 | Interest | | 5.00 | |
| 1917 | Sep 15 | Interest | | 5.00 | |
| 1917 | Oct 1 | Interest | | 5.00 | |
| 1917 | Oct 15 | Interest | | 5.00 | |
| 1917 | Nov 1 | Interest | | 5.00 | |
| 1917 | Nov 15 | Interest | | 5.00 | |
| 1917 | Dec 1 | Interest | | 5.00 | |
| 1917 | Dec 15 | Interest | | 5.00 | |
| 1917 | Total | | | 100.00 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 6 7 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Reuben Julius Goldstein Sr. | | | | 9 4 82 215 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | MONTH DAY YEAR | | 62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| North Carolina | | United States | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | 3102 Beckenham Court | | Staff Specialist | | Laboratory | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13a. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 3102 Beckenham Court | | | |
| Joseph J. Goldstein | | Mary Robertson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Yes | | WW II | | 231-09-8257 | | 2309 Ness Lane | |
| | | | | Reuben Goldstein Jr. | | Silver Spring, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon</u> | | | | | | | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV</u> 19 <u>80</u> , to <u>Sept</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>[Signature]</u> | | MD | | <u>Dr. D. Fleamery</u> | | 9/14/82 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | 23b. ADDRESS | | | | | |
| JOHN G. LODMELL, MD | | 1811 Prince Philip Dr. Olney Md 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY | |
| Burial | | September 7, 1982 | | Parklawn Memorial | | Rockville, Montgomery Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey Funeral Homes, P.A. | | SEP 9 1982 | | <u>[Signature]</u> | | | |

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CHILEAN





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 AE (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 24068 | | | |
|--|--|------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rose Hirschfeld Goldstein | | | | | | 2a. DATE KNOWN OF DEATH MONTH 11 DAY 15 YEAR 1982 | | | | | | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH 12 DAY 27 YEAR 1927 | | 6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. | | 7c. DATE PRONOUNCED DEAD MONTH 11 DAY 15 YEAR 1982 | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | | | 7d. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST DAVID MIDDLE HIRSCHFELD LAST HIRSCHFELD | | | | | | 15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE VOGEL LAST VOGEL | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 135-54-9171 | | 17. INFORMANT Address Terrace, #409; Beth. Md. Sidney M. Goldstein; 7420 Westlake | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 8880 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YR | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10. Fracture L hip | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/14/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L Hip | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-11 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall in Nursing Home | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N.H. | | | | 21f. LOCATION STREET Montrose Rd CITY OR TOWN Rockville COUNTY Mont STATE MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) Dep MEDICAL EXAMINER | | | | | | DATE SIGNED Sept 16, 1982 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Aaron Welfare Soc. Cem. | | | | 23d. LOCATION CITY OR TOWN HARTFORD COUNTY CONNECTICUT STATE CONNECTICUT | | | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner was notified and a report filed.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 6 9 | | | |
|--|--|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST <i>William L LEONARD GRAVES</i> | | | | MONTH DAY YEAR <i>Sept. 16 1982</i> | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>CAUCASIAN</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11-17-11</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>70</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>GREENSKEEPER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>COUNTRY CLUB</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i> | | | | 13b. COUNTY <i>MONTGOMERY</i> | | 13c. CITY OR TOWN <i>WHEATON</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>JESSE C. GRAVES</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH HARDING</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II 578-05-5506</i> | | 17. INFORMANT <i>SON</i> ADDRESS <i>4402 GRIDLEY ROAD</i> <i>STEPHEN L. GRAVES SILVER SPRING, MD. 20906</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1629 IMMEDIATE CAUSE (a) Carcinoma of Lung</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | (b) _____ (c) _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1978</i> to <i>Sept 16 1982</i> that (I) (we) last saw the deceased alive on <i>9/16</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Robert Benack</i> | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/16/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT BENACK</i> | | | | 22e. ADDRESS <i>SILVER SPRING, MARYLAND</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>BURIAL</i> | | 23b. DATE <i>9/20/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | 25a. DATE RECEIVED BY REGISTRAR <i>SEP 20 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Benack</i> | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|---|--------------------------------------|---|--|
| 8 2 2 4 0 7 0 CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN MARY GRONTKOWSKI | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 07 82 | | 2b. HOUR 7:10a_M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 28, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58 | | IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Pa. | | 13b. COUNTY Luzerne | | 13c. CITY OR TOWN Nanticoke | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 51 W. Green Street (18634) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Chepolis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Shipkowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | | | 16b. SOCIAL SECURITY NO. 195 20 4294 | | 17. INFORMANT ADDRESS John Grontkowski, same as patient (18634) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS DUE TO, OR AS A CONSEQUENCE OF (c) OVARIAN CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from July 26 , 19 82 , to Sept. 7 , 19 82 , that (we) lost saw the deceased alive on Sept. 7 , 19 82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard A. Sorace M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 9/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SORACE | | | | 22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Trinity | | 23d. LOCATION CITY OR TOWN COUNTY STATE Nanticoke, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 7 1 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Roseanne Gertrude Grotzinger | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1982 | | 2b. HOUR 5:45 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10/04/20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pennsylvania | | | | 13b. CITY OR TOWN St. Marys | | 13c. STREET ADDRESS 11 Wehler Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl H. Yetzer, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Fitzgerald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 166-14-9549 | | 17. INFORMANT ADDRESS Karen Grotzinger, dau., 2212 Washington Ave. #101A., Silver Spring, Md 20910 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a). Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b). Ovarian Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 September 1982, to 29 September 1982, that (in two) lost saw the deceased alive on 29 September 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE C A Harmon | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 30, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C A Harmon | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE October 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE St. Marys Elk PA. | |
| 24. FUNERAL DIRECTOR NAME Gartner - Sandison Funeral Home | | | | 24b. ADDRESS 316 East Diamond Gaithersburg, MD | | | |
| 24c. DATE REC'D. BY REGISTRAR OCT 4 1982 | | | | 25. REGISTRAR'S SIGNATURE J. A. Crist | | | |

BP

ON, 10/10/1911, 10/10/1911, 10/10/1911 - 10/10/1911

October 2, 1962, at 11:00 AM

Leitend

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 24072 | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Betty Terry Gundersen | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Sept 22 1982 | |
| 1. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR July 1924 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD Sept. 22 1982 | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. 12. CITIZEN OF WHAT COUNTRY? USA 13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Ft. Belk Wash 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Advent 1400p | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD 13b. CITY OR TOWN Prince Georges Adelphi 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 1923 Sarsoga Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Terry 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kaminsky | | | | | | | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 218 84 6062 17. INFORMANT ADDRESS same as above C. Bertrand Gundersen (Husband) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John Rogers M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER DATE SIGNED Sept 22 1982 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John Rogers ADDRESS 1919 Seminary Rd. S.S.Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9/25/82 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H. Ave. S.S.Md. 25a. DATE REC'D. BY REGISTRAR SEP 23 1982 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | |

5904 BP
DHMH - 17
(VR A15 ME (5))
20M 4 / 82

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked at item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 7 3

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Earl CLINTON Hadlock | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 29 82 | | | 2b. HOUR 7:30 A M | |
| 3. SEX male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 30 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY G.P.O. | |
| 13a. STATE md | | 13b. COUNTY PRI GEORGES | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS H. HADLOCK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES MARTIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 009-09-2972 | |
| 17. INFORMANT SON | | ADDRESS 2001 KINGSHOUSE ROAD | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26, 1982, to 9/29, 1982, that (I) (we) lost the deceased alive on 9/28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jerome S. Collins MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome S. Collins MD | | 22e. ADDRESS 11161 New Hampshire Avenue Silver Spring MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON | | 23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PRI GEO MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25. DATE REC'D. BY REGISTRAR OCT 7 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
JANUARY 1, 1901

ALBANY:
J.B. LIPPINCOTT & CO.
PRINTERS
1901

THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 7 4 | | | |
|---|--|--|--|--|--|--|--|-------------------|--|-----------------|-----|-------|----------|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| CONRAD | | BEATRAM | | HALL | | | | 9/22/82 | | | | | 150 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | | |
| MALE | | WHITE | | 4 7 27 | | 53 | | MONTHS | | DAYS | | HOURS | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Kentucky | | U.S. | | | | Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION (TYPE OF WORK, FARM, HOME, BUSINESS, ETC.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| TAKOMA PK. MD. | | Washington Adventist Hospital | | Prob. Control | | Mr. Western Metal Decorat | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | |
| California Los Ang. | | Azusa | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 506 East Duell | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Charles W. Hall | | LuRissia Sword | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 383-20-6431 | | Hospital Records | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) <u>sepsis (overwhelming)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>came from respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>3 months</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 9/25/1982 | | Oakdale Meml. Park, | | Glendora, Los Ang. Calif. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Takoma Funeral Home | | N.W. Wash. D. C. | | SEP 27 1982 | | John J. Smith | | | | | | | |

MEDICAL CERTIFICATION

Kentucky
 Washington Evangelist Hospital, 1001 Eastern Hotel, Detroit, Mich.
 California Ins. Co., 1001 Eastern Hotel, Detroit, Mich.
 Charles W. Hall
 383-50-6431 Hospital Records
 ***** Insurance Board *****

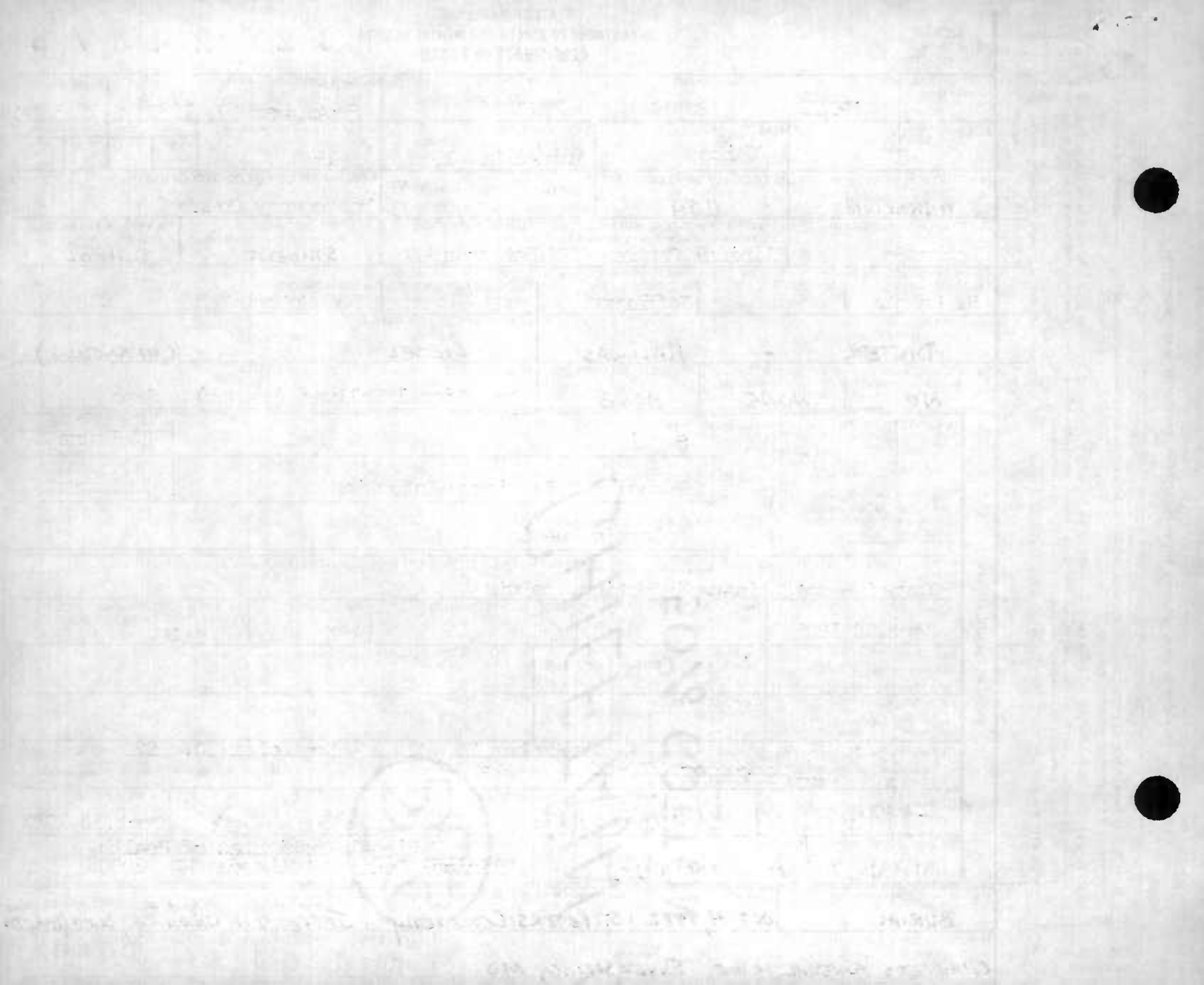
Bureau
 1001 Eastern Hotel, Detroit, Mich.
 383-50-6431 Hospital Records
 1001 Eastern Hotel, Detroit, Mich.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 7 5 REG. NO. | | | | |
|---|--|---|--|--|--|--|---|----------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN WALTER HALLWAS | | | | September 30, 1982 | | | | 12:15AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR August 26, 1963 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 19 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Bethesda, MD | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | | |
| 13a. STATE S. Dakota | | 13b. COUNTY JACKSON | 13c. CITY OR TOWN Jefferson | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 305 McCook Lake 57038 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DIETER - HALLWAS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIESEL - (UNKNOWN) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS Mrs. Liesel Hallwas (Mother) Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2849 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Invasive Soft Tissue Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Aplastic Anemia | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 72 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Invasive soft tissue infection, pelvis | | | | | | | | |
| 19a. DATE OF OPERATION Sept. 29, 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 7, 1982, to September 30, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 30, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Nancy A. Union MD | | | | DEGREE MD | | 22c. DATE SIGNED Sept. 30, 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NANCY A. UNION | | | | 22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT 4, 1982 | 23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE JEFFERSON, UNION CO. SOUTH DAKOTA | | | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | ADDRESS SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Lewis | | | | |

BP



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IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 7 6 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Randolph W Hamerdinger Sr.</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <u>Sept, 21, 1982</u> <u>9 58 AM</u> | | | |
| 3 SEX <u>Male</u> | | 4 RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>Aug. 14, 1911</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington DC</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Takoma Park</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Supervisor</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Navy Hydrographic</u> | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>PG</u> | | 13c. CITY OR TOWN <u>Morningside</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Harry Hamerdinger</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Hetta Raitz</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>Yes WWII</u> | | | |
| 16b. SOCIAL SECURITY NO. <u>577 26 7835</u> | | 17. INFORMANT <u>Jacqueline Hohbein</u> | | | | ADDRESS <u>5830 Carol Ct. Huntingtown, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CORONARY ARTERIOSCLEROSIS</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 DAYS</u> <u>3 YRS</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>METASTATIC OAT CELL CARCINOMA OF (R) LUNG</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>JUNE, 1982</u> to <u>SEPT 20, 1982</u> , that (I) (we) last saw the deceased alive on <u>SEPT 20, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>James A. Brown, MD</u> | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/21/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. BROWN, MD</u> | | | | 22e. ADDRESS <u>6525 BELCREST RD. HYATTSVILLE, MD 20782</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>24 Sept 82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Clinton PG Md</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Robert E. Wilhelm</u> | | | | ADDRESS <u>Funeral Home Suitland, Md</u> | | 25a. DATE REC'D BY REGISTRAR <u>SEP 28 1982</u> | |

MEDICAL CERTIFICATION



Handwritten text, mostly illegible due to fading and bleed-through. Some visible words include "MAY 11 1961" and "RECEIVED".

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 202-343-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 0 7 7 | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | REG. NO. | | | |
| CLEMENT DAVIS HAMM JR. | | | | 2a. DATE OF DEATH SEPTEMBER 10 1982 | | | |
| 3. SEX MALE | | | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH JULY 11 1929 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 | |
| 11. CITY OR TOWN OF DEATH BETHESDA | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA | | | | 13b. COUNTY FAIRFAX | | 13c. CITY OR TOWN MCLEAN | |
| 14. FATHER'S NAME CLEMENT DAVIS HAMM | | | | 15. MOTHER'S MAIDEN NAME NANNIE FAULKNER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 1953-1982 | | 17. INFORMANT HELEN WHITE HAMM (WIFE) MCLEAN, VIRGINIA 22101 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LUNGS WITH METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 30 JULY 1982 to 10 SEPTEMBER 1982, that (I) (we) last saw the deceased alive on 10 SEPTEMBER 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dennis J. Azuma LT MC USNR | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10 SEPT 1982 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. AZUMA, LT, MC, USNR | | | | 22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | ADDRESS SILVER SPRING, MARYLAND | | 25a. DATE REGD. BY REGISTRAR SEP 16 1982 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The *State* requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH-16 50M (1/81)
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 7 8 | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (PRINT) <i>Paul DeALBERT HARDING SR.</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-10-82</i> | | 2b. HOUR <i>2:38</i> M. | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>Nov. 14, 1904</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hauling Cont.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i> | | 13c. COUNTY <i>Montgomery</i> | | 13d. CITY OR TOWN <i>Silver Spring</i> | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS <i>12615 Holdridge Rd. 20906</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Zachariah Harding</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary B. Thompson</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>579-12-2770</i> | | 17. INFORMANT <i>Paul D. Harding, Jr.</i> | | | | ADDRESS <i>same as 13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> 4140 DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Chronic Renal Failure</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/9</i> 19 <i>82</i> , to <i>9/10</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>9/9</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED <i>9/10/82</i> | |
| 22b. SIGNATURE <i>R. T. Benack</i> | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. T. Benack MD</i> | | 22e. ADDRESS <i>4715 Colie DR. Wheaton, Md</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>cremation</i> | | 23b. DATE <i>Sept. 11, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lee Funeral Hm. Washington, D.C.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Francis H. Barber</i> | | | | P.O. Box 998 ADDRESS <i>Laytonsville, Md.</i> | | 25a. DATE RECEIVED BY REGISTRAR <i>SEP 15 1982</i> | | | | | |
| | | | | | | REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | | | |

MEDICAL CERTIFICATION



85 88-9-9

White
Nov. 11, 1904

Montgomery

USA

Alabama

Oliver Springs
Hauling Cont. Tunneling

Montgomery Oliver Springs
x 12014 Holbrook Rd. 20000

Geological
Mapping
B. Thompson

570-10-2700 and B. Thompson, Jr. same as 13

Station
Oct. 11, 1904
B. Thompson, Jr.
Lynchburg, Va.
Lynchburg, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 0 7 9 | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myra M. Hardy | | | | | | 2a DATE OF DEATH MONTH DAY YEAR September 24, 1982 | | 2b HOUR 7:25p | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR January 31, 1879 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 103 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cascade, Iowa | | 7b CITIZEN OF WHAT COUNTRY? United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10 CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY At home | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Washington, DC | | 13c CITY OR TOWN Washington, DC | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 3900-Watson Place, Northwest | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Beatty Moore | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Wightman | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 579-60-8082 | | 17 INFORMANT ADDRESS Margaret H. Potter (Daughter) Same as #13 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Aspiration Pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sept 24 6:05pm | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident | | | | | | | | | | Sept 24 7:25pm | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident | | | | | | | | | | Sept 13, 1982 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1979 , 19____, to Sept 24 , 19____, that (I) (we) last saw the deceased alive on 6:05pm Sept 24 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. Morgan O'Donoghue | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept 24 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES MORGAN O'DONOGHUE | | | | 22e. ADDRESS 3301 New Mexico Ave N.W. Wash D.C. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-25-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | | |
| 24 FUNERAL DIRECTOR NAME J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | |

1. The first of these is the fact that the
 2. United States is a free country.
 3. The second is the fact that the
 4. United States is a democratic country.
 5. The third is the fact that the
 6. United States is a country of laws.
 7. The fourth is the fact that the
 8. United States is a country of freedom.
 9. The fifth is the fact that the
 10. United States is a country of justice.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 0 8 0 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada m Hart | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 13 82 | | 2b. HOUR 145 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 21 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 86 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? Md. Baltimore Baltimore YES | | | | 13e. STREET ADDRESS 3391 Dulaney St., Balt. 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter J. Bender | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie - Spies | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-09-1497 | | 17. INFORMANT ADDRESS Frederick J. Hart 441 Valley Rd. Watchung, N. J. 07060 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4340 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years 2 years | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): - | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 24 19 80 to Sept 13 19 82 , that (I) (we) lost saw the deceased alive on Sept 10 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE James R. Moore Jr. | | | | DEGREE MD | | 22c. DATE SIGNED 9-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS 207 Brookes Ave Gaithersburg Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md. | |
| 24. FUNERAL DIRECTOR Rosebell G. Sandison 316 E. Diamond Ave., Gartner Sandison F. H. Gaithersburg, Md. 20877 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John T. Canick | | | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24081 | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Furness Louise Hertig | | | | | | 7a. DATE KNOWN OF DEATH ESTIMATED Sept 4 1982 | | 7b. HOUR 11:29 AM | | | |
| 1. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 28 13 89 | | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 89 | | 7c. DATE PRONOUNCED DEAD Sept. 4 1982 | | 7d. HOUR 11:29 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Tek. Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Systems Analyst | | 12b. KIND OF BUSINESS Civil Service | |
| 13a. STATE MD | | | | | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William C. Lavin | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie C. Lyle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 429-01-1056 | | 17. INFORMANT sister ADDRESS Wilodene L. Smith 4516 Twinbrook Road Fairfax, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rog#RS | | | | TITLE (SPECIFY) M.D. Prof | | | | MEDICAL EXAMINER 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROG#RS | | | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | | DATE SIGNED Sept 6 1982 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HEDGE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE GURDON CLARK ARKANSAS | | | |
| 24. FUNERAL DIRECTOR Francis J. Collins Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |
| 5000 BP 500 Univ. Blvd. W. Silver Spring, Md. | | | | | | | | | | | |

Atlanta

E. S. A.

2

Child Service
Computer System Analyst

Division

C.

Lawyer

Justice

C.

Life

422-01-1554

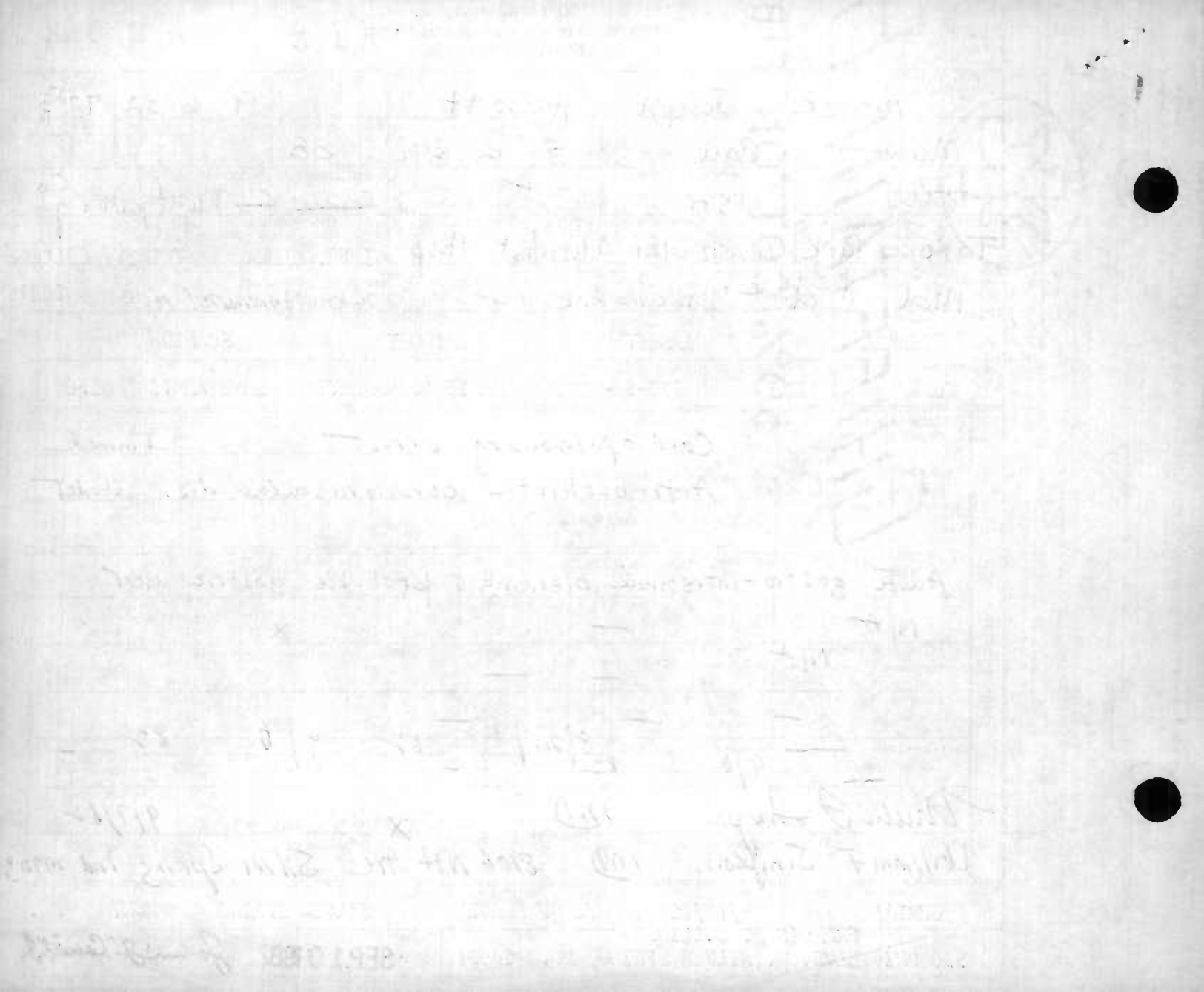
Associate I. Child Welfare Department Room
Folkston, Ga.

500 Main. Blvd. W. Silver Spring, Md.
Francis J. Perkins Insurance Home
Perkins

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 8 2
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Patrick Joseph Hassett</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 6 82</i> | | 2b. HOUR <i>7 45 PM</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Cau</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 8 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>IRELAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges Montgomery Co MD</i> | |
| 10. CITY OR TOWN OF DEATH <i>Tokoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>INFO. CLERK</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>TRINITY COLLEGE</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME, GIVE RESIDENCE BEFORE ADMISSION) <i>MD PRINCE GEORGE</i> | | 13c. CITY OR TOWN <i>Tokoma Park</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>7610 Hagerwood Ave 20912</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>MICHAEL HASSETT</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>BRIDGET SCANLON</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) <i>YES</i> | | 16b. SOCIAL SECURITY NO. <i>WW 1 577-50-0778</i> | | 17. INFORMANT ADDRESS <i>MARIE L. HASSETT SAME AS 13 WIFE</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular dis. Under</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immed</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Acute gastro-intestinal bleeding i probable gastriz ulcer</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>N/A</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>N/A</i> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— — — 19 82</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>—</i> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <i>—</i> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/20/82</i> to <i>9/6/82</i> , that (I) (we) lost the deceased alive on <i>9/6/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>William F. Simpson, MD</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/7/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William F. Simpson, MD</i> | | 22e. ADDRESS <i>8106 NH Ave Silver Spring Md 20903</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>9/10/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i> | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>SILVER SPRING MONT MD</i> | |
| 24. FUNERAL DIRECTOR <i>FRANCIS J. COLLINS</i> NAME <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | |



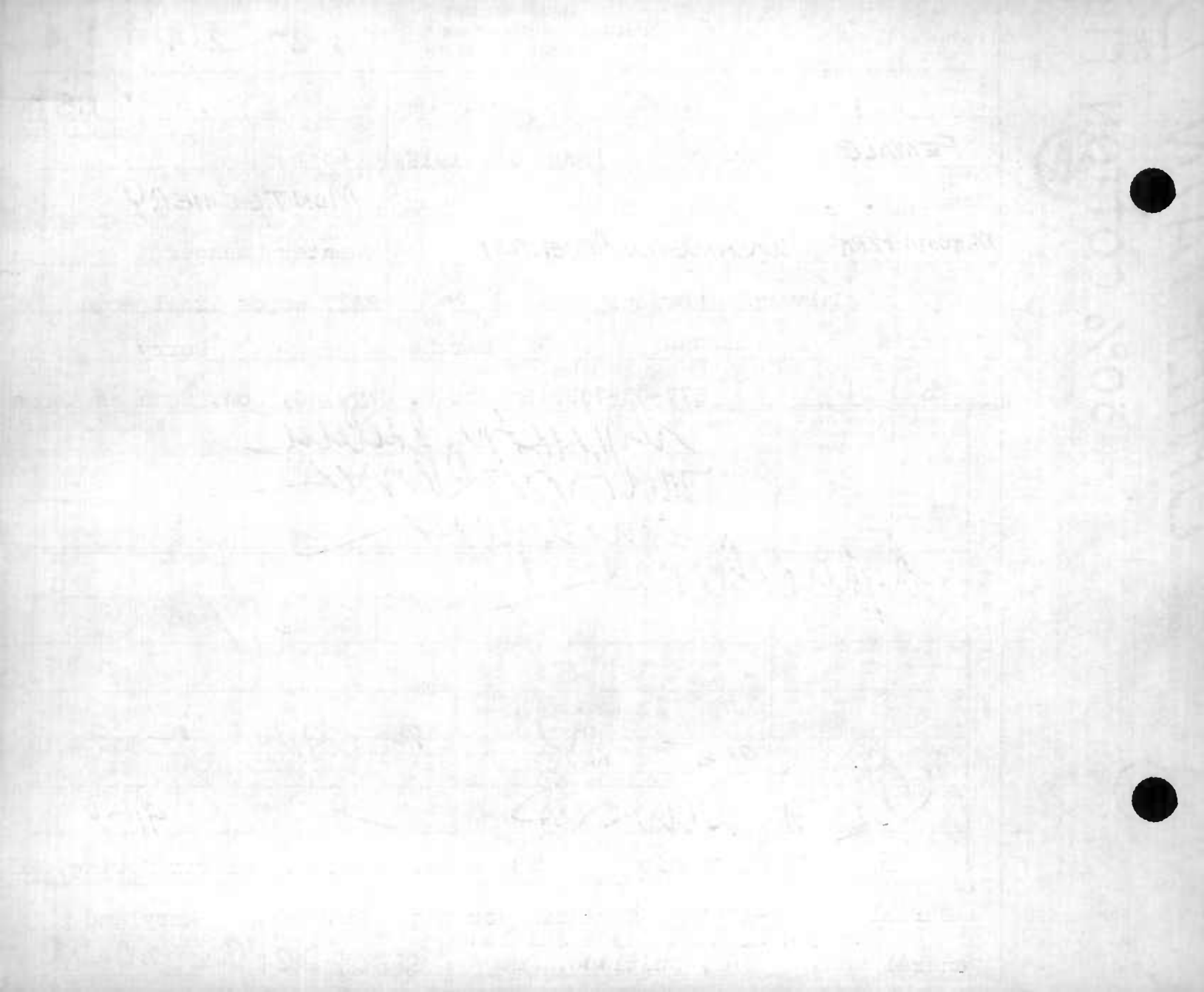
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 8 3 REG. NO. | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME FIRST MIDDLE LAST Frances Alice Haywood | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 16 82 | | 2b. HOUR 118 AM | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Mar 10 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Theater Manager | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Calvert | | 13c. CITY OR TOWN Owings | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2017 Boyds Trail Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Morris Husband | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Perry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 577-05-7939 | | 17. INFORMANT ADDRESS Robert F. Haywood, Son, Same as Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) <i>systemic pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <i>hypertension</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>9/16</i> 19 <i>82</i> , to <i>9/16</i> 19 <i>82</i> , that (1) (we) last saw the deceased alive on <i>9/16</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN <i>Dr. Lewis H. Dennis</i> | | | | 22c. DATE SIGNED 9/16/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr, Lewis H. Dennis | | | |
| 22e. ADDRESS 831 Univ. Blvd. E., Silver Spring, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-18-82 | | 23c. NAME OF CEMETERY OR CREMATORY Southern Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | | | 24b. ADDRESS 4308 Suitland Rd., Suitland, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

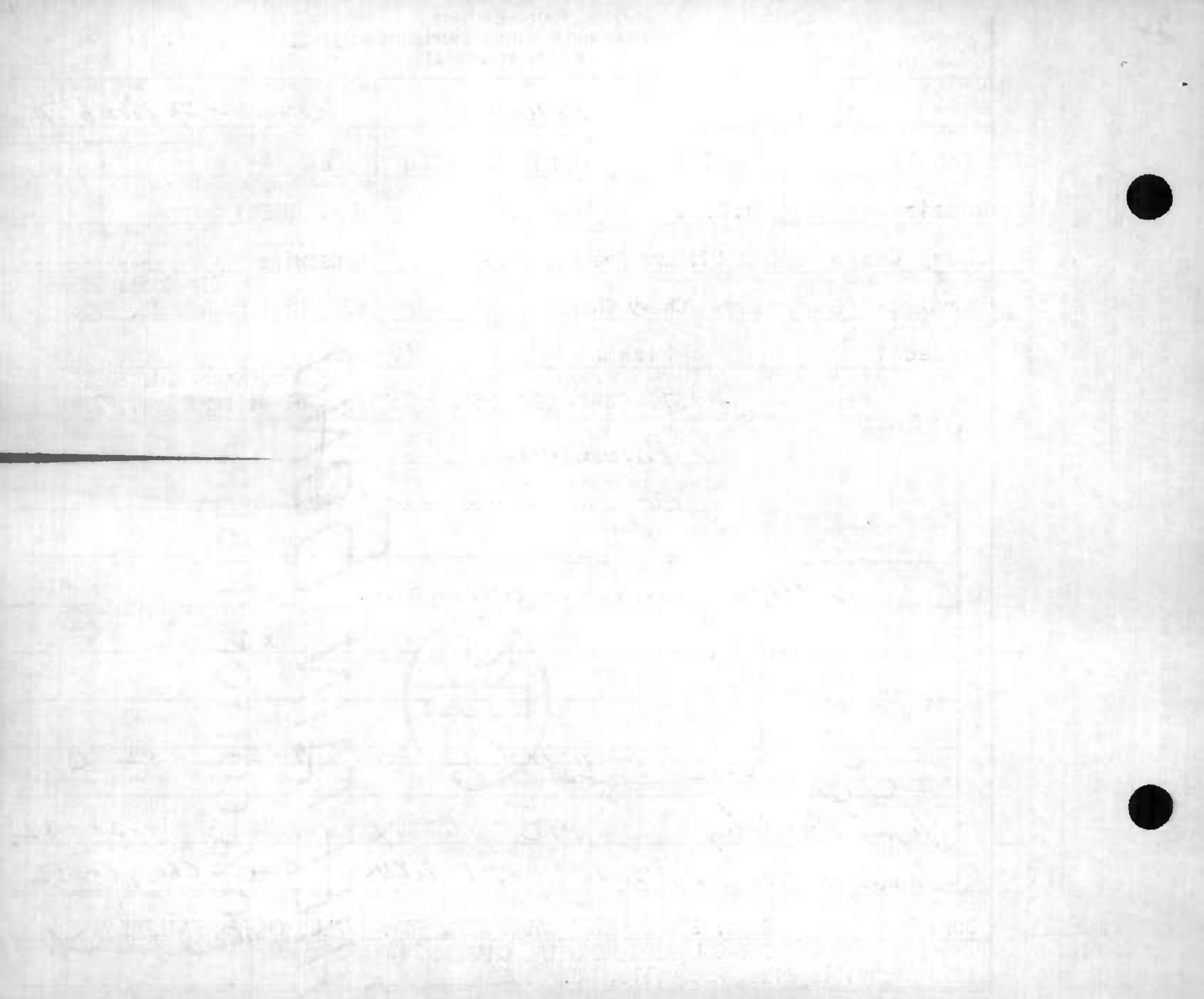
8 2 2 4 0 8 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|--|--|-------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rebecca Heller</i> | | | 2a DATE OF DEATH MONTH DAY YEAR <i>September 28 1982</i> | | 2b HOUR M <i>6:10 P</i> | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>April 1, 1898</i> | | |
| 6 AGE (IN YEARS LAST BIRTHDAY) <i>84</i> | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD. | | | | |
| 10 CITY OR TOWN OF DEATH <i>Chevy Chase</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4701 Willard Avenue, #908</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | |
| 12b KIND OF BUSINESS OR INDUSTRY ----- | | 13a STREET ADDRESS <i>4701 Willard Avenue, #908</i> | | | | |
| 13b COUNTY <i>Montgomery</i> | | 13c CITY OR TOWN <i>Chevy Chase</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e ZIP CODE <i>20815</i> | | 14 FATHER'S NAME FIRST MIDDLE LAST <i>Mordecai Wishman</i> | | | | |
| 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(UNKNOWN)</i> | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | | |
| 16b SOCIAL SECURITY NO. <i>579-42-8225</i> | | 17 INFORMANT NAME ADDRESS <i>Chedy Chase, Md. 20815</i> <i>D; Milton Heller; 4701 Willard Ave., #908</i> | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>3109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>multiple decubitus ulcerations</i> | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (1) (this hospital) attended the deceased from <i>11-19</i> , 19 <i>80</i> , to <i>9-28</i> , 19 <i>82</i> , that (1) (we) last saw the deceased alive on <i>8-12</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death. | | | | | | |
| 22b SIGNATURE <i>James H. Brodsky</i> | | DEGREE <i>MD</i> | | 22c DATE SIGNED <i>9-28-82</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>James H. Brodsky MD</i> | | 22e ADDRESS <i>4701 Willard Ave. Chevy Chase</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b DATE <i>Sept. 30, 82</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. GDN.</i> | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH; FAIRFAX; VA.</i> | | 24 FUNERAL DIRECTOR NAME ADDRESS <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> <i>1170 Rockville Pike; Rockville, Md. 20852</i> | | | | |
| 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE <i>OCT 1 1982</i> | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Margaret MIDDLE Elliott LAST Higgins MARGARET E. HIGGINS | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 14 1982 | | | | 2b. HOUR 2:25 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 / 15 / 21 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 61 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) New Mexico | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary (Ret) | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | |
| 13a. STATE MD | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5220 MARLYN DR. ; GLENME PARK | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Danna Satterly Elliott | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vena Teresa Pool | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 525-18-8554 | | 17. INFORMANT ADDRESS Raphael J. Higgins. Same as item 13 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5344 GASTRIC HEMORRHAGE, EXSANGUINATING DUE TO, OR AS A CONSEQUENCE OF (b) ANASTAMOTIC ULCER / GASTRITIS DUE TO, OR AS A CONSEQUENCE OF (c) ANTRECTOMY - BILLROTH II for ULCER | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 HOURS 8 MONTHS 20 YEARS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SHOCK ; LEFT FEMORAL THROMBOSIS ; AORTOFEMORAL GRAFT | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/13/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1.) HEMORRHAGE ; 2.) THROMBOSIS | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/13 , 19 82 to 9/14 , 19 82 , that (I) was lost saw the deceased alive on 9/13 , 19 82 , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Alan N. Schulman, MD | | | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN N. SCHULMAN, MD | | | | | | | | 22e. ADDRESS 9715 MEDICAL CENTER DRIVE ROCKVILLE, MARYLAND - 20850 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | | 23b. DATE 9/17/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | 23d. LOCATION Silver Spring, Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. | | | | | | | | ADDRESS 5130 Wisc. Ave., N.W. Washington D.C. | | 25. DATE RECEIVED BY REGISTRAR SEP 20 1982 | |
| | | | | | | | | REGISTRAR'S SIGNATURE John J. Canary | | | |

BP

Marshall Islands

New Mexico

U.S. Govt.

Post

Address

Name

Address

City

State

U.S. Govt. (Post Office)

958-18-077

on

9/27/1982 Date of Review Completed

Serial

Joseph Smith's Book of Mormon

1100 fac. vol. 1, 1830-1840

Released by Dr. Maule Deputy Medical

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be obtained within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 0 8 6 | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Alder E. Highland, Jr. | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | |
| | | | | | | | | 9-9-82 | | 4:10 PM | | | |
| 3. SEX Male | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 3, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIAGE STATUS XXX NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIR OF MIL TRANS. | | 12b. KIND OF BUSINESS OR INDUSTRY ASSO. OF AMER. R.R. | | | | | |
| 13a. STATE MARYLAND | | | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALDER E. HIGHLAND | | | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST ELIZABETH WARD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) WW II 712-14-2785 | | 17. INFORMANT MARY E. HIGHLAND | | ADDRESS SAME AS 13 WIFE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic Obstructive Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF: (c) 10 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/1/1982 to 9/9/1982 that (I) (we) last saw the deceased alive on 9/9/1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert C. Macon | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/10/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon | | | | | | 22e. ADDRESS 809 Viens Mill Rd. Rockville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |

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Handwritten text on the right margin, possibly a date or reference number, oriented vertically.

Main body of the document containing multiple lines of handwritten text, including dates like "17-12-9-0" and "1900", and various illegible words and phrases.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 8 7 REG. NO. | |
|---|--|---|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Florence Hill | | 2a. DATE OF DEATH MONTH DAY YEAR September 30, 1982 | | | 2b. HOUR 3:35P M | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 1, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 19902 Oak Hill Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Hill | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Mitchell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS 15708 Thompson Rd. Jeannette Colbert (Sister) Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> <u>2030</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21 MONTHS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN.</u> 19 <u>81</u> , to <u>SEPT 30,</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>SEP 30,</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Eugene P. Flannery</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9/30/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Flannery, M.D. | | 22e. ADDRESS 18111 Prince Philip Dr. Olney, MD 20832 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-5-82 | | 23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | 24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1982 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | | | | |

WITNESSED

WITNESSED

WITNESSED

WITNESSED

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WITNESSED

WITNESSED

WITNESSED

DHMH-17
(VR A15 ME (S))
15M2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 2 4 0 8 8 REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|---|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES GRIFFITH HILL | | | | | | 2a. DATE KNOWN OF DEATH Sept 4 1982 | | | | 2b. HOUR 11 | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH Sept. 1, 1926 | | 6. AGE 56 | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | | 7c. DATE PRONOUNCED DEAD September 4, 1982 | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE HOME ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Refrigeration Repairman | | | | 12b. SECOND BUSINESS Food | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Beltville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4701 Cardinal Avenue | | | | | |
| 14. FATHER'S NAME Henry W. Hill | | | | | | 15. MOTHER'S MAIDEN NAME Daisy Griffith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW 11 215 20 7581 | | 17. INFORMANT Mildred S. Hill ADDRESS Same as #13 (Wife) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) M.D. | | | | DATE SIGNED Sept 4 1982 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | | ADDRESS 1919 Seminary Road Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brunswick Frederick Md. | | | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. ADDRESS Hyattsville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | | | | | |

Special Agent in Charge
Federal Bureau of Investigation
Washington, D. C.
1919

Dear Sir:
Reference is made to your letter of the 11th inst.
concerning the above captioned matter.
The Bureau is at present unable to furnish the information
requested.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 8 9 | |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| FOR 1- STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helena Annie Hilton</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-9-82</i> | | 2b. HOUR <i>4:35</i> P.M. | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12-11-23</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Scotland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Beautician</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Hair Salon</i> | | | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Sil. Spr.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>20910 718 Silver Spring Avenue</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Steele</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Sadler</i> | | | | ADDRESS <i>11705 Goodloe Rd. Sil. Spr., Md.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>---</i> | | 17. INFORMANT <i>Edward J. Woodrow Sil. Spr., Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic left breast Ca</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>8-30 82</i> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>9-9 82</i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-8 82</i> to <i>9-9 82</i> , and that (my) opinion of death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>G. Sengstack M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>9-9-82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Sengstack, M. D.</i> | | | | 22e. ADDRESS <i>9241 Columbia Blvd. Sil. Spr., Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9/11/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spr. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR (NAME) <i>Warner E. Pumphrey, Inc.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i> | | | | | |

VIAGGIO DI STAMPA

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 4 0 9 0 REG. NO. | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ricky Fred Himmelfarb | | | | | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 9 13 1982 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH (MONTH DAY YEAR) Oct. 4, 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 13 1982 | |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | |
| 1b. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Paving | | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanford Himmelfarb | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marilyn Rubinstein | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | (IF YES, GIVE WAR OR DATES) ----- | | 16b. SOCIAL SECURITY NO. 215-68-9226 | | 17. INFORMANT ADDRESS Silver Spring, Md. 20906 Stanford Himmelfarb; 12400 Downer Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 12 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 9/13/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | | | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE SEP 14 1982 | | | | | |
| 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | | | | | | | |



[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 9 1

| | | | |
|--|------------------|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa Madeline Hixenbaugh | | 2a. DATE OF DEATH MONTH DAY YEAR September 3, 1982 | |
| 2b. HOUR 11:45 ^a M | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 09/28/1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE West Virginia | | 13b. COUNTY Kanawha | |
| 13c. CITY OR TOWN East Bank | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 1901 1st Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Walter Williams | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Rose Jarrett | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 235-60-0957 | |
| 17. INFORMANT Ralph B. Hixenbaugh, husband, same | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>SMALL CELL CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CACHEXIA SECONDARY TO (a)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RIGHT PLEURAL EMPHYSEMA</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 YEARS MONTHS WEEKS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>25 May</u> , 19 <u>82</u> , to <u>3 September</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>3 September</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE C.A. Harmon MD | | 22c. DATE SIGNED 9/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.A. Harmon MD | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md 20205 | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Sept. 7, 1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY Montgomery Mem. Park | | 23d. LOCATION London, West Virginia STATE | |
| 24. FUNERAL DIRECTOR NAME Ives Funeral Home 2847 Wilson Blvd. Arlington, Va. 22201 | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

| No. | Plant Name | Common Name | Family | Origin | Remarks |
|-----|------------|-------------|--------|--------|---------|
| 1 | ... | ... | ... | ... | ... |
| 2 | ... | ... | ... | ... | ... |
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| No. | Plant Name | Common Name | Family | Origin | Remarks |
|-----|------------|-------------|--------|--------|---------|
| 11 | ... | ... | ... | ... | ... |
| 12 | ... | ... | ... | ... | ... |
| 13 | ... | ... | ... | ... | ... |
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| 19 | ... | ... | ... | ... | ... |
| 20 | ... | ... | ... | ... | ... |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 9 2

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Priscilla B. Hixson | | | 2a DATE OF DEATH MONTH DAY YEAR September, 13, 1982 | | | 2b HOUR 7:10pm | | | |
| 3 SEX female | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR AUG. 7, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 8b CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | |
| 10 CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY Home | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Silver Spring | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 3631 S. Leis. World Blvd. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Albert F. Bogue | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Jarvis | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-56-6625 | | 17 INFORMANT ADDRESS Clayton H. Hixson Same as item # 13 | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OAT CELL CARCINOMA OF LUNG</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>81</u> , to <u>SEPT 13</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>SEPT 13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Eugene P. Flannery, M.D. | | | | DEGREE M.D. | | | | 22c DATE SIGNED 9/14/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Eugene Flannery, M.D. | | | | 22e ADDRESS 18111 PRINCE PHILIP DR. OLNEY, MD. 20832 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE Sept. 14, 1982 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Md. | | | |
| 24 FUNERAL DIRECTOR'S NAME Joseph Gawler's, Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. | | | | 25a DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b REGISTRAR'S SIGNATURE John J. Carver | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

BP

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

16

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 0 9 3

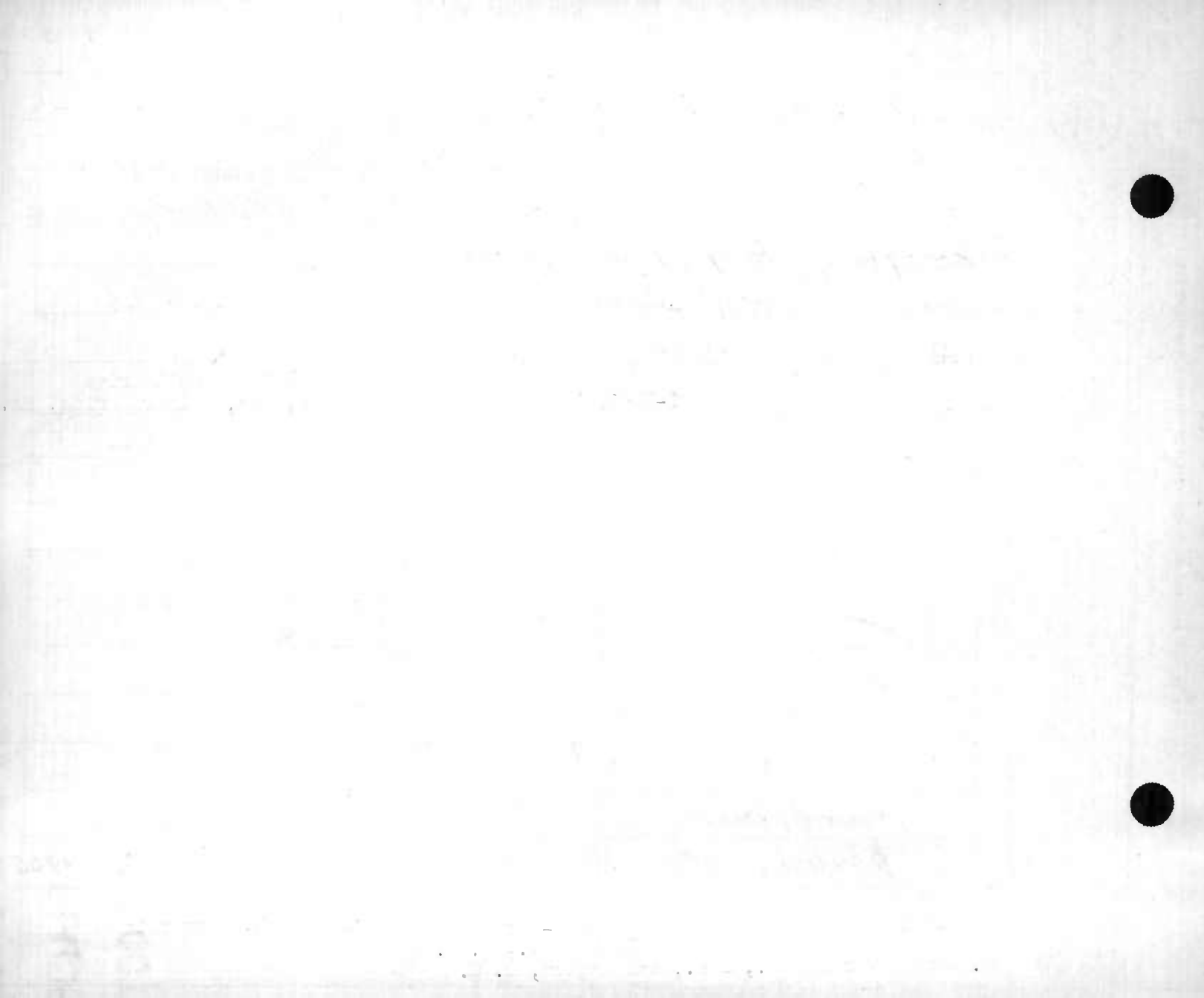
REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARGUERITE A. HOFFMAN | | | 2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 82 | | | 2b. HOUR 2 05 AM | | | | | | | | | | | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH 8 DAY 27 YEAR 06 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7. IF UNDER 24 HRS HOURS 0 MIN 0 | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH DAKOTA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOSPITAL SUCH FACILITY GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1010 ROSWELL DR | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST William MIDDLE Stoebe LAST Stoebe | | | | 15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Keough LAST Keough | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO 502-18*3522 | | | | 17 INFORMANT Patricia Feistritz, Dau, Silver Spring, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/5 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 9/5 | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. 9/5 MONTH 9 DAY 19 YEAR 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 9/5 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/5 | | | 21f. LOCATION STREET 9/5 CITY OR TOWN 9/5 COUNTY 9/5 STATE 9/5 | | | 21g. LOCATION CITY OR TOWN 9/5 COUNTY 9/5 STATE 9/5 | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/5 to 9/6 19 82 , that (I) (we) lost saw the deceased alive on 9/6 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Raymond Bass | | | DEGREE RAYMOND BASS MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/7/82 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS MD | | | 22e. ADDRESS 3929 FERRARA DR. WILKINSON MD 20906 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 8 Sep 82 | | | 23c. NAME OF CEMETERY OR CREMATORY Ship - to | | | 23d. LOCATION CITY OR TOWN Saint Paul COUNTY Minnesota STATE Minnesota | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc. | | | ADDRESS 1432 U St., N. W. | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 2 4 0 9 4 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion J. Holland | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 18 1982 | | 2b. HOUR 5:00 p.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 12 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist | | 12b. KIND OF BUSINESS OR INDUSTRY Nat'l. Science Found. | |
| 13a. STATE D.C. | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3130 Wisconsin Ave., N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Delos L. James | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Walter | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 579-10-6494 | | 17. INFORMANT ADDRESS Bethesda, Md. Calvert. 6712 Michaels Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 days 12 hrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18/82 to 9/18/82 , that (I) (we) last saw the deceased alive on 9/18/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sam Duggin | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) 4301 48th St N.W. | | | | 22e. ADDRESS Wash. D.C. 20016 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/20/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Jo eph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

MEDICAL CERTIFICATION

Cremation 2/20/1982 Cedar Hill Crematory
 to sign "Cremation" form
 2130 Mac. Ave. N.E. Wash. D.C.

No 272-10-6494 Margaret J. O'Callahan, 2125 Michigan Drive
 Bethesda, Md.

DeLos J.

James

Anna

after

D.C. Washington 2130 Macomb Ave., N.E.

Rockville

Potomac Valley Nursing Home

Clark Typist

Nat'l. Science Found.

Montgomery

xx

U.S.A.

III.

Female

April 12 1914

88

HOLLIS

J.

I 1110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 0 9 5 | |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DOROTHY L HOLLIDGE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-29-82 | | 2b. HOUR 10:30 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 29 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own home | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 14607 Claude Lane 20904 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W. Goodman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Howard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Ernest B. Hollidge-son-6009 Jerry's Drive, Columbia, Md. 21044 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 MIN 4 HRS 30 MIN YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES MELLITUS HYPERTENSION | | | | | | | | | | | |
| 19a. DATE OF OPERATION 29 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 2 | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) 1 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1106 SPRING ST. Washington, DC | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/29 19 82 , to 9/29 19 82 , that (I) (we) lost saw the deceased alive on 9/29 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Arnold G. Levy MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 9-29-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY, M.D. | | | | 22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-30-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC | | | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | ADDRESS 11800 N.H. Avenue, Silver Spring, Md. | | 25a. DATE RECD BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. ... | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

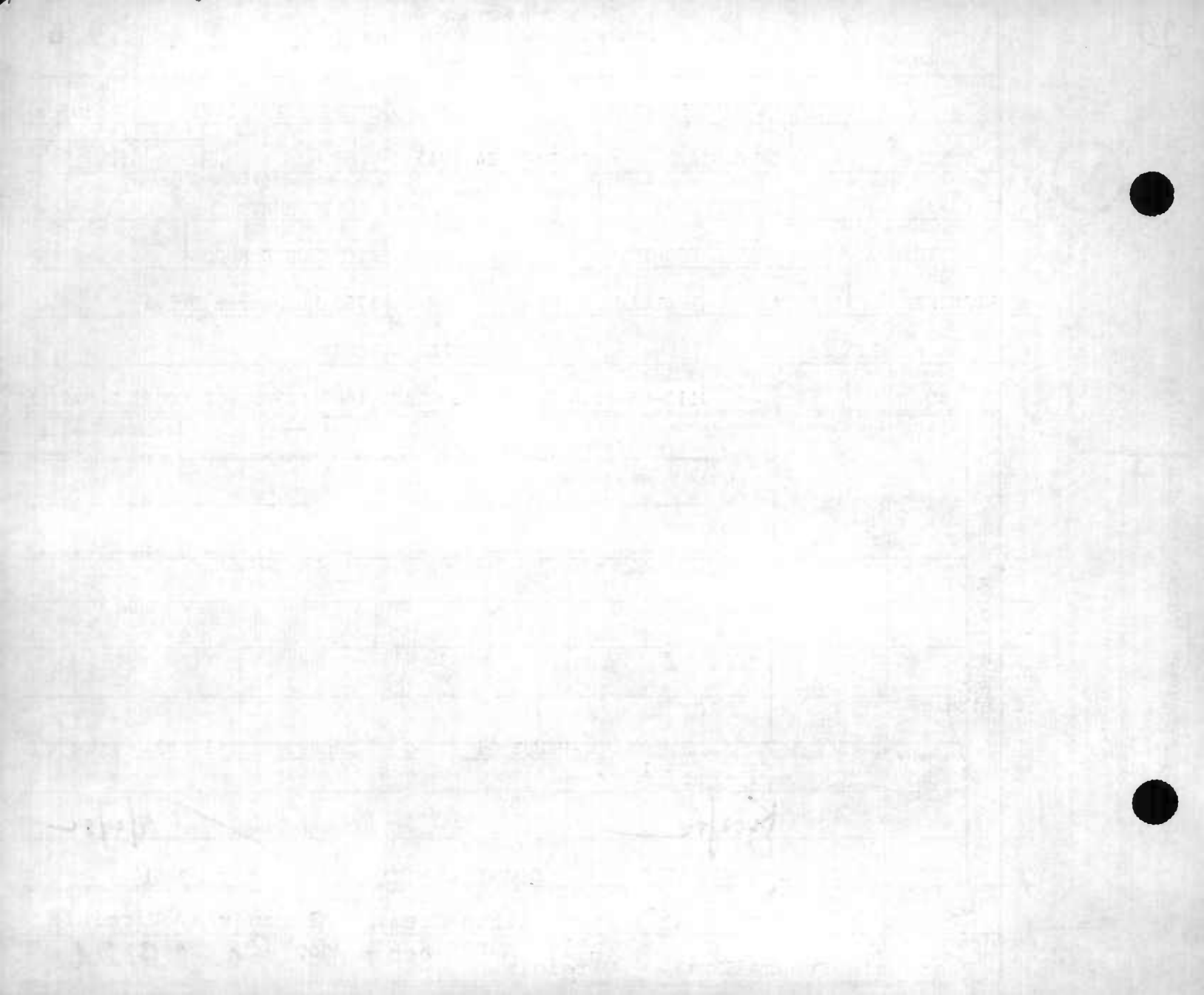
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|--|--|---|---|---|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 2 2 4 0 9 6 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| ELIZABETH HEBE HOUGLAND | | | | | SEPTEMBER 1 1982 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| FEMALE | | CAUCASIAN | | JANUARY 23 1915 | | 67 | | 6:05 am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| CANADA | | UNITED STATES | | | | MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | NAVAL HOSPITAL | | | | REGISTERED NURSE | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| VIRGINIA | | | FAIRFAX | | MCLEAN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| EARL STANLEY BARKER | | | | | GERTRUDE BRICKER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | 230 48 8810 | | ERIK HOUGLAND, 1803 DEVONWOOD COURT, KNOXVILLE, TN 37922 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) COPD/RESPIRATORY FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 31 19 82, to SEPTEMBER 1 19 82, that (I) (we) last saw the deceased alive on SEPTEMBER 1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | DATE SIGNED | |
| K. Lee | | | | | | | | 9/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| KENNETH LEE, LCDR, MC, USNR | | | | | NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | | | Sept. 3, 1982 | | Metropolitan Crem, | | Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR NAME | | | | | Falls Church Virginia | | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE | | |
| Pearson's Funeral Home, | | | | | | | SEP 7 1982 John J. Council | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Roger -J. Howell | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-01-82 | | | 2b. HOUR MIN. 7:30 A | | | | |
| 3. SEX Male | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 4-23-23 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SPECIAL AGENT | | 12b. KIND OF BUSINESS OR INDUSTRY F.B.I. | | |
| 13a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN WHEATON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12815 BLUHILL ROAD 20906 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROGER J. HOWELL, SR. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELLA THOMAS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. 193-16-7902 | | 17. INFORMANT ANNE C. HOWELL | | ADDRESS SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE 1579 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MIN. 6 MON | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a THROMBO PHLEBITIS AND PULMONARY EMBOLI | | | | | | | | | | |
| 19a. DATE OF OPERATION 8/14/82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 11 , 19 82 , to AUG 31 , 19 82 , that (I) (we) last saw the deceased alive on AUG 31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Harold S. Fidler M.D. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/1/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD FIDLER | | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 23d. LOCATION ROCKVILLE MONT MD. | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | | ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

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Page 2

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24098 | |
|--|---------------------|---|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST J. Ross Humphreys | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR Sept 21 1982 | |
| 1. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR July 30 01 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 81 | IF UNDER 1 YR. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept 21 1982 | | 2b. HOUR OF DEATH 8:45 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Advent Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Banker | | | 12b. KIND OF BUSINESS OR INDUSTRY Banking | | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 18708 Woodlane Circle Rd | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Humphreys | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Smith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 339-18-3830A | | 17. INFORMANT ADDRESS John Ross Humphreys, Jr. Gaithersburg, Md. 10351 Watkins Mill Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 Acute Myocardial Dis. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Yrs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20879 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) MD Dep. | | | | MEDICAL EXAMINER 1919 Seminary Rd., Silver Spring, Md. | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | DATE SIGNED Sept 21 1982 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME Gartner Sandison F.H. Gaithersburg, Md. 20877 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 0 9 9 REG. NO. | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angela Agnes Hurley | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-2-82 2b. HOUR 9¹⁰ A.M. | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 18, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY PRI. GEO. | | 13c. CITY OR TOWN GREENBELT | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WEBSTER HERBERT | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-74-9329 | | 17. INFORMANT SON ADDRESS 10014 TENBROOK DRIVE FRANCIS A. HURLEY, JR. SILVER SPRING, MD. 20901 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Severe Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: () | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-18- 19 80 , to 9-2- 19 82 , that (I) (we) lost saw the deceased alive on 9-2 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael R. Bolognese | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL BOLOGNESE | | | | 22e. ADDRESS GAITHERSBURG MONT MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carls | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.33
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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 0 0 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Ireland | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 9, 1982 | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7620 Maple Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Takoma Park | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bland Carter | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Pryor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 577-32-6747 | | 17. INFORMANT ADDRESS Lillian Johnson (daughter) Dickerson, Md. 20930 Big Woods Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart</i> 4140 DUE TO, OR AS A CONSEQUENCE OF <i>degenerate with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>arteriosclerotic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myopathy</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7, 1982, to 9/12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did, and not after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN <i>B.N. Rosenbaum</i> | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSENBAUM | | | | 22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md. | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | 24b. ADDRESS 246 N. Wash. St. Rockville, Md. 20850 | | 25a. DATE REG'D. BY REGISTRAR SEP 16 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | | |

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CHIEFMAN



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 15 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 0 1 REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Max Martin Jacobson | | | | 2a. DATE OF DEATH 9 3 82 | | 2b. HOUR 4:35AM | |
| 3 SEX Male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR July 12 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Montgomery Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Broadcasting Co. | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Simon Jacobson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jette Elsohn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Margaret G. Jacobson-wife-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>radiation before - Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute suppurative inflammation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>thrombotic heart disease</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 24 hours 20 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1982</u> to <u>September 2, 1982</u> , that (I) (we) last saw the deceased alive on <u>September 2, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Gregorio Kase</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 13 E DEER PARK DR - CATHERPOLE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9-7-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md. | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | 1800 N.H. Ave., S.S. Md. | | 25. DATE REC'D. BY REGISTRAR SEP 9 1982 | |
| | | | | 26. REGISTRAR'S SIGNATURE <u>John J. Lander</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to see.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

| FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. 82 24102 | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alvina H. Johnson | | 2a. DATE OF DEATH MONTH DAY YEAR 9-5-82 | | 2b. HOUR MINUTE 8:36 A.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 1-1916 | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MINS 8. UNDER 24 HRS. HOURS MINS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Tetonia Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK, NAME OF WORKING LIFE) Supt. Food Service | | 12b. KIND OF BUSINESS OR INDUSTRY (Retired) |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b. CITY OR TOWN Tetonia Park | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 810 Jackson Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Opp | | 15. MOTHER'S M maiden name FIRST MIDDLE LAST Elizabeth Breckle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 504-30-1390 | | 17. INFORMANT NAME ADDRESS Norman Johnson 810 Jackson Ave. Tet. Pk. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 1/2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15, 1982, to 9/5, 1982, that (I) (we) last saw the deceased alive on 9/4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Alfred Munzer | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Munzer M.D. | | 22e. ADDRESS 7600 Carroll Avenue Takoma Park Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 12-1982 | | 23c. NAME OF CEMETERY OR CREMATOR Woodworth Cemetery | |
| 23d. LOCATION (CITY OR TOWN) Tetonia Park | | 23e. COUNTY Nebraska | | 23f. STATE Nebraska | |
| 24. FUNERAL DIRECTOR NAME ADDRESS J. Arthur Kallert 254 Carroll St. N. W. SEP 9 1982 Joan J. Conner | | | | | |

Roby Released by Dr. Mayle
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
to Dr. Rosenberg

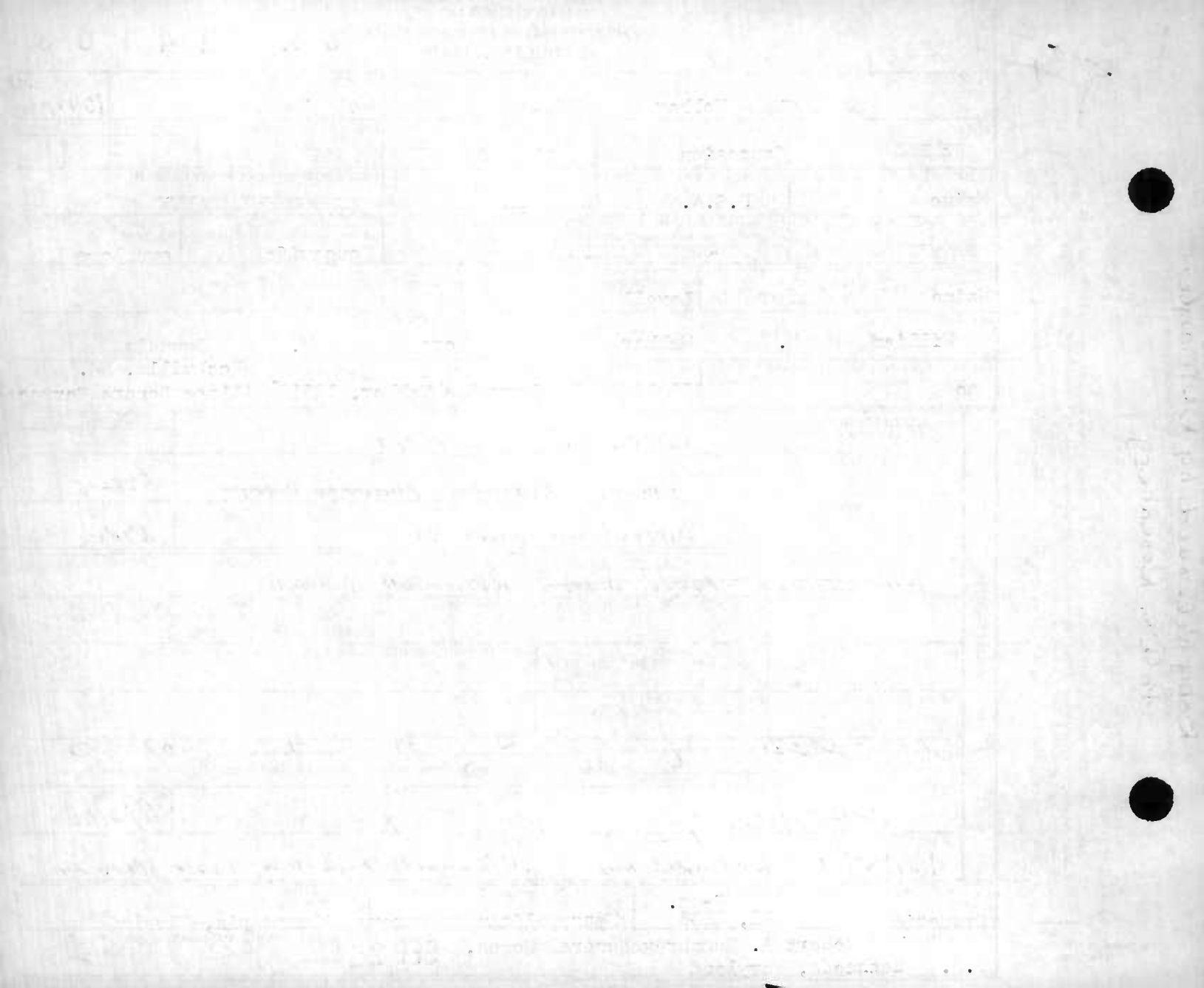
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 0 3 REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CHRISTINE Webber JOHNSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 19 82 | | 2b. HOUR 10:15 P.M. | |
| 3. SEX FEMALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 05 30 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| 13a. STATE Maine | | 13b. COUNTY Oxford | | 13c. CITY OR TOWN Lovell | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME William R. Webber | | 15. MOTHER'S MAIDEN NAME Dora M. Runnels | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 006 38 4936 | | 17. INFORMANT 20852 ADDRESS Rockville, Md. Lorraine Webber, 12513 Village Square Terrace | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC HEART DS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS 5 YRS. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ATHEROSCLEROTIC HEART DISEASE PERMANENT MYOCLONUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) the hospital attended the deceased from 2 19 79, to 9 19 82, that (2) we last saw the deceased alive on 6 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert L. Rosenberg, MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD | | 22e. ADDRESS 1131 UNIVERSITY BLVD W, SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME P.A. Bethesda, Maryland | | Robert A. Pumphrey, Funeral Homes, | | 25. DATE REC'D. BY REGISTRAR SEP 22 1982 | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4 / B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Jerome

Johnson

2a. DATE KNOWN
OF DEATH
☐ MONTH ☐ DAY ☐ YEAR
☒ 9/23 19 82

2b. HOUR

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

JAN. 30. 1918

6. AGE (IN YEARS
LAST BIRTHDAY)

69 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE
PRONOUNCED
DEAD
☐ MONTH ☐ DAY ☐ YEAR
 9/29 19 82

3. HOUR

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Wisconsin

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

 8. MARRIED ☐ NEVER MARRIED ☐
 WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

10. CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

7726 Sycamore Avenue

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

RETIRED

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Takoma Park

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

7726 Sycamore Avenue

14. FATHER'S NAME

FIRST

MIDDLE

LAST

JOHNSON

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

YES

(IF YES, GIVE WAR OR DATES)

W.W.II

16b. SOCIAL SECURITY NO.

387-12-4289

17. INFORMANT

ADDRESS

V.A. RECORDS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

4960 IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease.

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which
 gave rise to immediate
 cause (a) stating the under-
 lying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

None

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☐Inquiry ☒

and in my opinion

 death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL
SIGNATURE

TITLE (SPECIFY)

Deputy MEDICAL EXAMINER

DATE
SIGNED 9/30/82EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS 1919 Seminary Road
Silver Spring, Montgomery, Md.23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Oct. 1, 1982

23c. NAME OF CEMETERY OR CREMATORY

Maryland Veterans Cemetery

23d. LOCATION
CITY OR TOWN

Cheltenham

COUNTY

STATE Md

24. FUNERAL DIRECTOR
NAME

Takoma Funeral Home, Inc.

254 Carroll St. N. W.

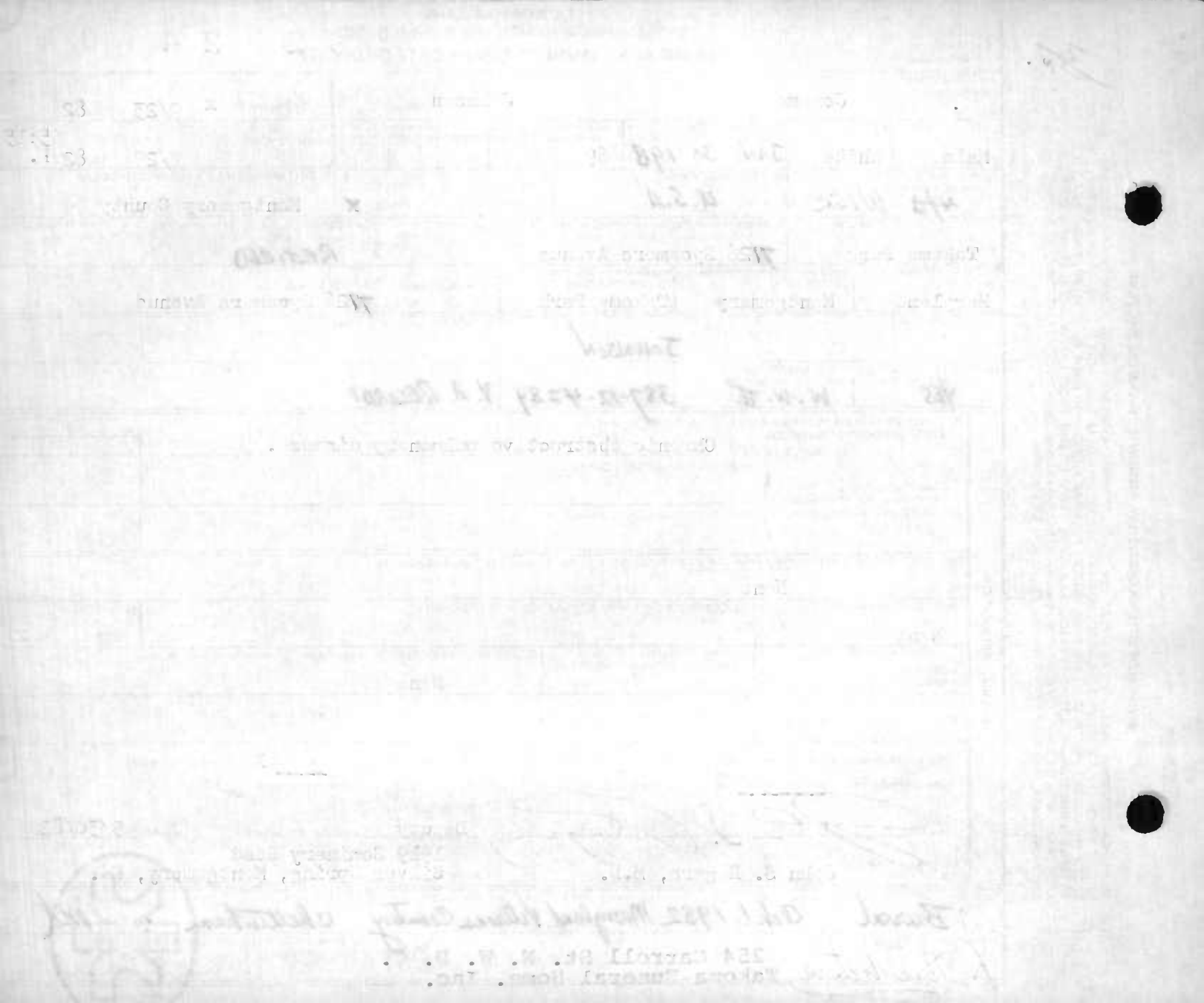
Takoma Funeral Home, Inc.

25a. DATE RECD. BY REGISTRAR

OCT 4 1982

25b. REGISTRAR'S SIGNATURE

John J. Connel



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8 2 2 4 1 0 5 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Louis Jefferson | | Joyce | | | | | | 9-2-82 | | 1:50 P.M. | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Black | | Dec. 10, 1915 | | 66 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | U.S.A. | | | | Montgomery County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| Bethesda | | SUBURBAN | | | | | | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| 13a. STATE | | | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2126 Yorktown Rd., N.W. | | | |
| Wash. D.C. | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Arthur H. Joyce | | | | Nannie Price | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Army | | | | 231-03-5454 | | Helen Joyce 2126 Yorktown Rd. N.W. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Respiratory Arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | 1 wk. | |
| (b) Cerebrovascular Accident | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from Nov. 1981, to Sep. 1982, that (1) I saw the deceased alive on 9-2-82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (2) I did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Carol L. Bender, MD DEGREE | | | | | | | | 22c. DATE SIGNED 9/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L. Bender | | | | | | | | 22e. ADDRESS 8600 Old Georgetown Rd. Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY STATE | | | |
| Burial | | 9/8/82 | | Parklawn | | Rockville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc. ADDRESS 7400 Ga., Ave, N.W. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

9-2-12/17

Topic

Topic

Montgomery County

Barbara Swanson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 also signify injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 1 0 6 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLA KATHERINE KADESCH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 15 82 | | 2b. HOUR 8:25 P.M. | | | |
| 3. SEX Female | | 4. RACE Caucasion | | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Legal Sectr. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Pr. Geo. 13c. CITY OR TOWN Takoma Park | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 811 Elm Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Chris Mueller | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Nehofer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (YES, NO OR UNKNOWN) | | 17. INFORMANT ADDRESS (Same as # 13 above) Rollen B. Kadesch | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1919 cerebral edema DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of the Brain DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of the colon | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 82 to 9/13 , 19 82 , that (I) (we) lost saw the deceased alive on 9/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/15/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR NAME John J. Walters ADDRESS 254 Carroll St. N.W. | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

Burial

7/12/1913

Rock Creek Cem.

Washington, D. C.

No

Chris

Kneller

Wife

Kneller

Rollin B. Kneller

(Same as above)

Maryland Tr. Co. Takoma Park X 811 Elm Avenue

Takoma Park

Washington Adventist Hosp. Beltsville

Legal Secy.

Illinois

U. S. A.

Secretary

Tennise

Concession

July 20, 1913

70

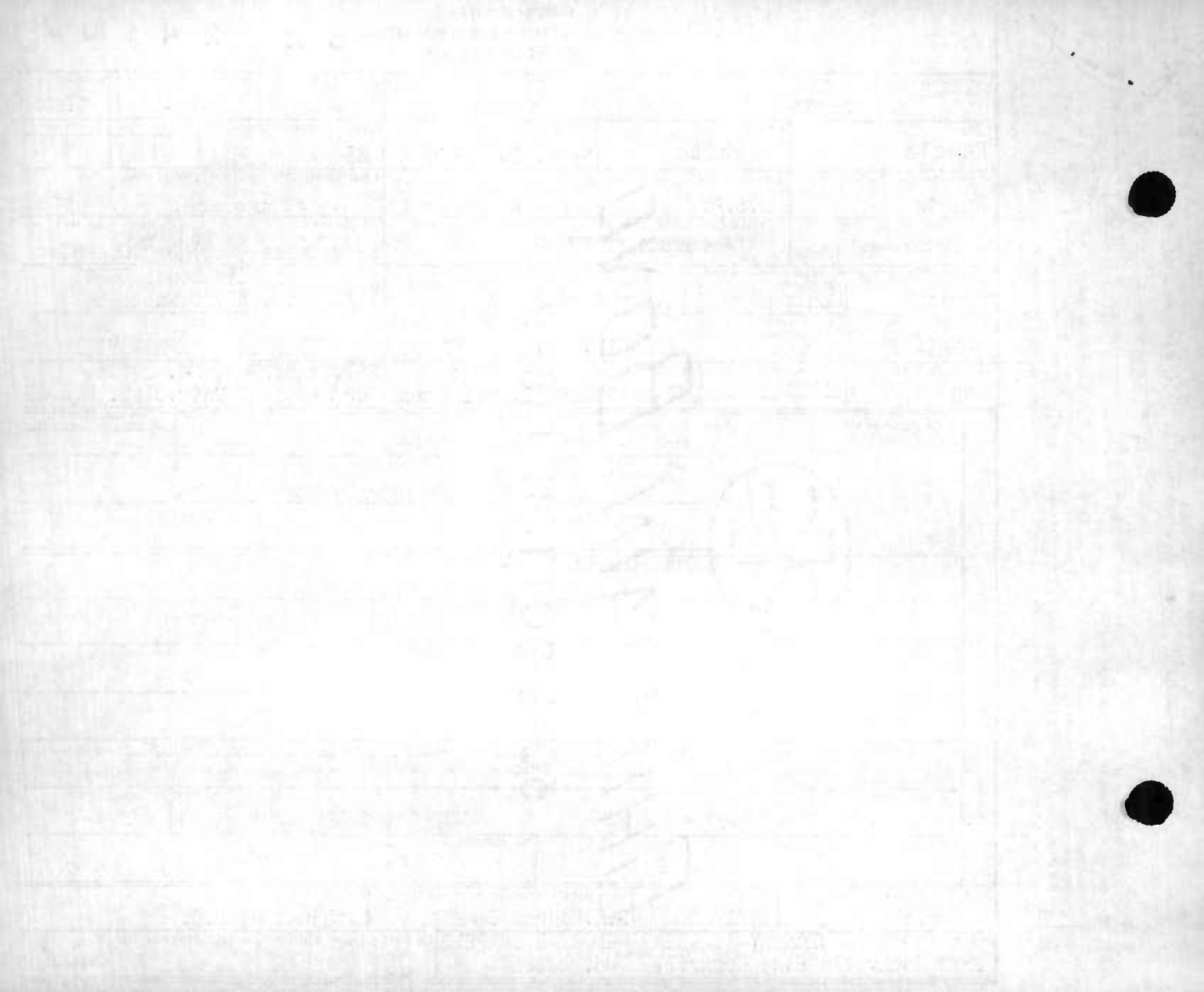
Released to Mr. Weinstein by Mr. Mayle
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 1 0 7 | |
|--|--|--|--|---|--|--|------------------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Annie Kahansky | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9.30.82. | | | 2b. HOUR 6:30A | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ZUSHIA KAHANSKY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FUMMA TZIPPKE KAHONOVICZ | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-54-7967D | | 17. INFORMANT Silver Spring, Md. 20902 Sylvia Grace Dorfman; 1121 Univ. Blvd., W., #105 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEP 30, 1982, to SEP 30, 1982, that (I) (we) lost saw the deceased alive on SEPT 30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 9/30/82 | |
| 22b. SIGNATURE Mark F. Weinstein MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK F. WEINSTEIN MD. | | | | | 22e. ADDRESS 11125 Rockville Pike Rockville MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY S.E. Hebrew Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DR MAYLE WAIVED

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 24108 | |
| 1. FOR - STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| JEANNE TE | | | | KALLINSKY | | | | 9 7 1982 3P | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| Female | | White | | Sept. 15, 1956 | | 66 YRS. | | MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda, Md. | | Suburban Hospital | | Secretary | | Private | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | | | Montgomery | | Bethesda | | | | 10250 West Lake Dr. #21 (20817) | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| AARON | | | | KALLINSKY | | SARAH | | | | SILBERMAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | | | 212-01-1907 | | Kate Shefter; Sister; 7501 Democracy Blvd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT, ACUTE 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HR | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| JOSEPH KING | | | | M.D. | | | | 9/7/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | CHERYL CHASE MD | | | |
| 6000 WISCONSIN | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 9/9/82 | | Ohel Yakov Cong. Cemetery | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 1170 Rockville Pike; Rockville, Maryland | | | | SEP 15 1982 | | | |



INSTITUTIONAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FREDERICK LLOYD KARDELL | | | 2a. DATE OF DEATH MONTH DAY YEAR September 15, 1982 | | 2b. HOUR 6:45A.M. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 3, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4012 Spruell Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manpower Specialist-Dept. Labor | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4012 Spruell Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Kardell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie - Hanson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II | | 17. INFORMANT Viola May Kardell-Address same as #13 above. | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) Renal Cell Carcinoma = Metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Gastrointestinal Hemorrhage | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19____, to 9-15 , 19 82 , that (we) last saw the deceased alive on 9-14-82 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE W. F. Cresswell | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Sept. 15, 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. F. Cresswell | | | | 22e. ADDRESS 2029 Q Street, N.W.-Washington, D.C. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | | |

MEDICAL CERTIFICATION



| | | | |
|--------------------|------------------|-------|------|
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |
| September 12, 1935 | WASHINGTON, D.C. | White | Male |

Handwritten notes and stamps at the bottom of the page, including dates like 1935 and 1936, and names like "R. C. ...".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------|--|---------------------|--|---------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | | 7. MIN. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | | 7. MIN. | |
| Shirley M. Katcher | | September 27, 1982 | | 10:15 | | A. | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | | | |
| Female | | White | | January 11, 1916 | | 66 | | YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Washington | | U. S. A. | | | | Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Chevy Chase | | 5608 Warwick Place | | Occup. Therapist | | Self | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Chevy Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 5608 Warwick Place | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Royall Wood | | Fay | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| No | | 593-18-1792 | | David A. Katcher | | 5608 Warwick Place | | | | | | | |
| | | | | | | Chevy Chase, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 1991 | | IMMEDIATE CAUSE (a) | | Adeno. Cancer of the Liver | | 3 Months | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Metastatic Cancer of the Liver | | | | | | | | | |
| | | (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| N/A | | N/A | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | N/A | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| N/A | | N/A | | N/A | | | | | | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from 9 - 27, 1982, to 9 - 27, 1982, that (we) last saw the deceased alive on 9 - 27, 1982, and that (we) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | | | |
| George T. Economos | | 9 - 27 - 1982 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| George T. Economos | | 2141 K St. N.W. - Washington, D. C. 20037 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Cremation | | 9-29-1982 | | Cedar Hill Crematory | | Suitland Prince George's Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Joseph Gawler's Sons | | OCT 4 1982 | | John J. Conner | | | | | | | | | |
| 5130 Wisc. Ave. Wash., D.C. | | | | | | | | | | | | | |

Cleared by: DR. FRANCIS C. MAYLE - MEDICAL EXAMINER

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, please note any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED BY: DR. LINDA C. WATTS - MEDICAL UNIT

Joseph Gaudin's home 2130 Wisc. Ave. Wash., D.C.

Operation 9-2-1982 Cedar Hill Crematory Suitland Prince George's Md.

George T. Economos 2141 K St. N.W. - Washington, D.C. 20037

9-2-1982

9-2-82

N/A

9-2-82

N/A

N/A

N/A

N/A

N/A

X

Metastatic Cancer of the Liver

Adeno. Cancer of the Liver

593-18-1982 David A. Hatcher Chevy Chase, Maryland

Novell Wood

Mining

X 3008 Warwick Place

Montgomery Maryland

Chevy Chase

3008 Warwick Place

Chevy Chase

3008 Warwick Place

Washington

U.S.A.

Montgomery

January 11, 1982

White

Female

Hatcher

M.

Grifley

September 27, 1982 10:15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 1 1

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 9-30-82 | | 10:20 A | |
| 3. SEX Female | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 2-19-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES P. MOFFITT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BECKER | | 13e. STREET ADDRESS 4725 JASMINE DRIVE 20853 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 282-14-8756 | | 17. INFORMANT JOHN J. KELLIHER | | ADDRESS SAME AS 13 HUSBAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 DUE TO, OR AS A CONSEQUENCE OF (b) INTRA ABDOMINAL METASTASES DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA, PRIMARY SITE UNKNOWN 1 year | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 4, 19 82, to SEPT 30, 19 82, that (I) (we) last saw the deceased alive on SEPT 30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hubert J. Alpent | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 30 Sept 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert J. Alpent | | 22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR OCT 7 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Kelliher | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

MEDICAL CERTIFICATION

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DE TTS2

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MAY
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TTS2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

CLEARED BY DR. F. C. MAYLE, DEPUTY MEDICAL EXAMINER

11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 1 2
REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Owen Kennedy | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 12 82 | | | 2b. HOUR 12:00 PM | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6 29 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17060 King James Way Apt. 904 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired upholsterer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Montgomery | | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 17060 King James Way 20877 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Kennedy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary U. Millikan | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --- | | | |
| 16b. SOCIAL SECURITY NO. 246 26 8826 | | | 17. INFORMANT Rockville, Md. 20853 Wilton L. Kennedy 13716 Flint Rock Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>arteriosclerosis heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension; profuse sweating</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension; profuse sweating</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>Feb 19 19 82</u> to <u>Sept 13 19 82</u> , that (we) last saw the deceased alive on <u>Feb 19 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Michael R. Dobridge</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>Sept 13 82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Michael R. Dobridge | | | 22e. ADDRESS 13975 Connecticut Ave. Silver Spring, Md. 20906 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Interment Burial</u> | | | 23b. DATE 9/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Floral Gardens Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE High Point, N.C. | | |
| 24. FUNERAL DIRECTOR NAME 1331 Rockville Pike Rockville, Md. 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | |

10/10/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 4 1 1 3 REG. NO. | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy Elizabeth KIDDA</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-16-82</i> | | 2b. HOUR <i>7:22 PM</i> |
| 3. SEX <i>FEMALE</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>10-15-01</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>MARYLAND</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MARYLAND</i> | | | 13c. CITY OR TOWN <i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>WALTER CRUIT</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>EMMA I. FERRY</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>579-09-0242</i> | | 17. INFORMANT ADDRESS <i>DORIS A. CUSHMAN SAME AS 13 DAUGHTER</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <i>1629 Metastatic carcinoma of left lung</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> |
| IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of left lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Rheumatoid arthritis</i> | | | | | |
| 19a. DATE OF OPERATION <i>9-13-82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rheumatoid arthritis</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-13-82</i> to <i>9-16-82</i> that (I) (we) last saw the deceased alive on <i>9-16-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.) | | | | | |
| 22b. SIGNATURE <i>Jason Geiger MD.</i> | | DEGREE | | 22c. DATE SIGNED <i>9-17-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jason Geiger MD.</i> | | 22e. ADDRESS <i>8830 CAMERON STREET SILVER SPRING MD. 20910</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>9/20/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i> | |
| 23d. LOCATION (CITY OR TOWN) <i>BALTIMORE</i> | | COUNTY <i>MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> | | | 25. STATE DEPT. OF HEALTH AND MENTAL HYGIENE REGISTRAR'S SIGNATURE <i>John J. Canine</i> | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | SEP 20 1982 | | |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|------------------|---|------------------|---------------------|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE OF DEATH | | | 2d. HOUR | | |
| FRANCIS | | | KIRK Jr. | | | 9-6-82 | | | 9-6-82 | | | 8:00A | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | |
| Male | Caucas. | Dec. 4, 1928 | 53 YRS. | | | Montgomery County, | | | Bethesda | | | 4853 Cordell Avenue | | |
| 12a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 12b. CITIZEN OF WHAT COUNTRY? | | | 12c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 12d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12e. KIND OF BUSINESS OR INDUSTRY | | |
| Pennsylvania | | | United States | | | XXX Montgomery County, | | | Shoe Salesman | | | Dept. Stor | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Maryland | | | Montgomery | | | Bethesda | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 4853 Cordell Ave. (20814) #820 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Francis J. | | | Gertrude K. Huth | | | Yes | | | WW II | | | (Sister) 202 Guilford Ave. Eleanor Wilson Collingswood, N.J. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | |
| | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | | | | |
| Margarita A. Korell | | | M.D. Assistant | | | 9-7-82 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Removal | | | 9/9/82 | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| NAME ADDRESS | | | SEP 14 1982 | | | John J. Carver | | | | | | | | |
| Anatomy Board | | | Balto., Md. | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

7

QWDC

REBIL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 1 1 5 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Richard A. Knubbe | | | | 9/5/82 | | | | 7:33am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| male | | white | | 8/19/18 | | 63 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | | USA | | | | Olney Mont MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Olney | | Montgomery General Hospital | | | | Budget Analyst | | NOAA | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Montgomery | | Olney | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5 Gelding Ct. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | |
| Frederick | | William | | Knubbe | | Helen | | B. Saxton | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| yes | | | | WW II | | Maryann Knubbe same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffused histiocytic lymphoma</u> 2000 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>July 1981</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Diabetes mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>9/5</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state (did not) view the body after death.) | | 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <u>9/5/82</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 9/8/82 | | Gate of Heaven Cemetery | | Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME <u>Tyson Wheeler Funeral Home, Inc.</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland 20852</u> | | | | | | 25. DATE REC'D. BY REGISTRAR <u>SEP 9 1982</u> REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

FOR
1 - STATE
REGISTRAR

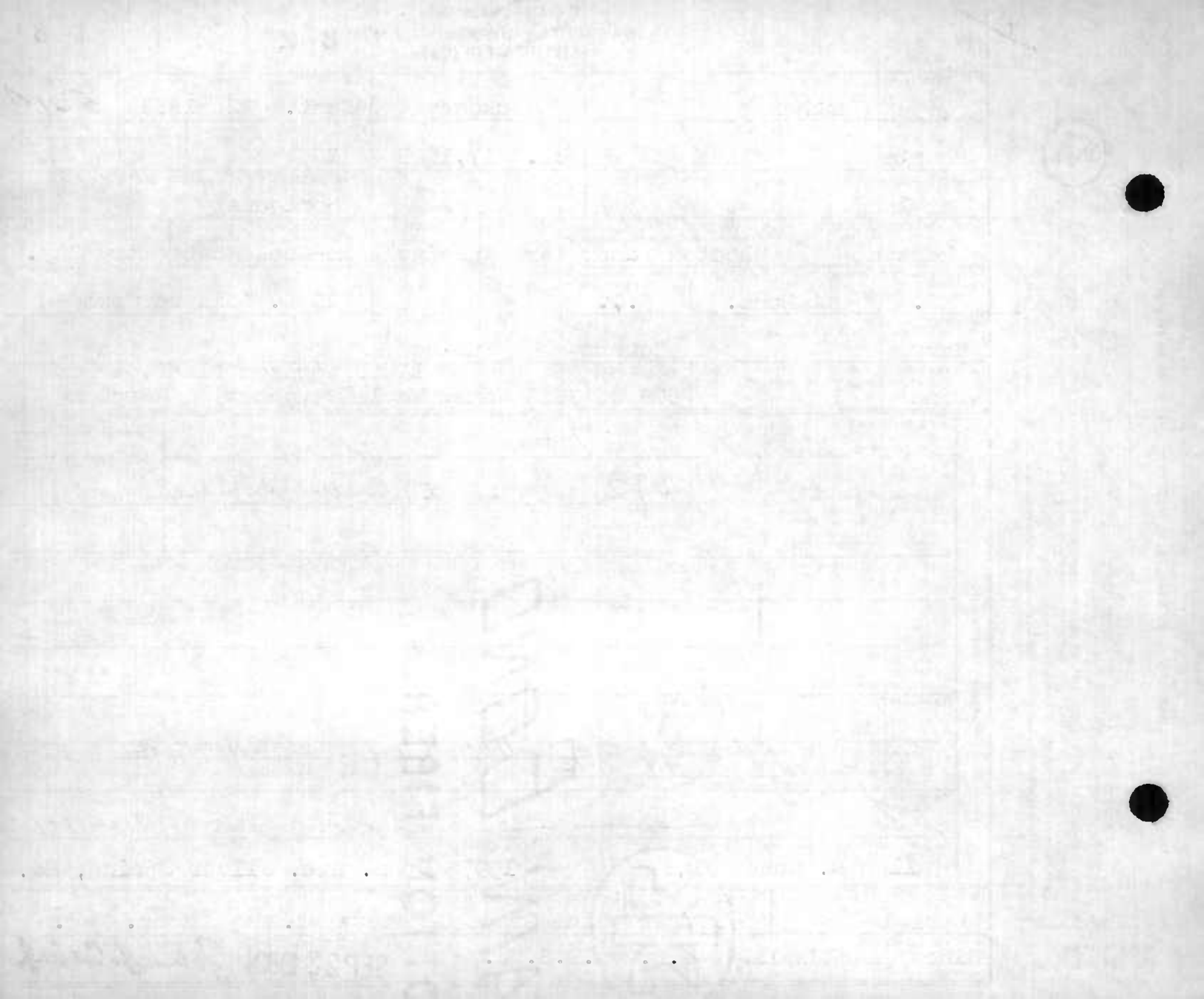
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 2 4 1 1 6

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Esther A Koockogey | | | 2a DATE OF DEATH MONTH DAY YEAR Sept. 22 1982 | | | 2b HOUR 5:21 AM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | |
| 10 CITY OR TOWN OF DEATH Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor Care Nursing Home-Cook Montgomery Cty. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Md. | | | 13b COUNTY Mont. | | 13c CITY OR TOWN S.S. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Harry Bowers | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Long | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None | | | |
| 16b SOCIAL SECURITY NO. 578 26 7622 | | | 17 INFORMANT 17663 Horizon Place, Derwood Maryland Janet Maple (Daughter) | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360 CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction, Probable Cerebral Arteriosclerosis (c) Due to, or as a consequence of | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/22/74 to 9/22/82 , that (I) (we) lost 11/22/74 saw the deceased alive on 9/22/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Allan B. Cohan</i> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan B. Cohan MD, PA | | | | | 22e. ADDRESS 13975 Conn. Ave. Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery Mt. Airy | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mont. Md. | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|-------------------------|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN EARL KUHN | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 9 2 19 82 | | 2b. HOUR 10 |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 27 1923 | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 59 | IF UNDER 1 YR. MONTHS DAYS 0 0 | IF UNDER 24 HRS. HOURS MIN. 0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | 10. CITY OR TOWN OF DEATH Silver Spring | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHIEF ESTIMATOR P & P CONST. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | |
| 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS 1404 Gridley Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN B. KUHN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE GRUNNINGER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 579-20-2226 | | 17. INFORMANT ADDRESS DOROTHY W. KUHN SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis. (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) M.D. Def. | | DATE SIGNED Sept 2 1982 | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD. | | 23e. DATE REC'D. BY REGISTRAR SEP 7 1982 | | 23f. REGISTRAR'S SIGNATURE John J. Carver | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

05519 101 141853

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 1 1 8 | | | | | | | | | |
|--|--|------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|---|--|---------------|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY WILLIE KUNZE JR. | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED Sept 24, 82 XXX 21X 032X | | | | | | | | | | 2b. HOUR M | | | | | | | | | | | | | | | | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 11 19 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 9/24/82 19 12:37 AM | | | | | | | | | | 2d. HOUR M | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park, Md. | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator | | | | 12b. KIND OF BUSINESS OR INDUSTRY ADT | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 1614 Moffet Rd | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry W. Kunze, Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Hammer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII | | | | 16b. SOCIAL SECURITY NO. 218 18 3533 | | | | 17. INFORMANT ADDRESS (wife) Mary E. Kunze #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | TITLE (SPECIFY) MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers, M.D. | | | | | | | | | | DATE Sept. 24/1982 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 27, 1982 | | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. Taltavull | | | | | | | | | | 25. REC'D. BY REGISTRAR 1067 1 1982 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4748 Wisc. Ave. N.W. Wash. D.C. 20016 | | | | | | | | | | 26. REGISTRAR'S SIGNATURE John J. Givier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

COLLAGE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 | 2 | 4 | 1 | 1 | 9 | | | | |
|---|--|------------------------|--|--|---|--|--|---|--|---|---|---|---|--|---|---|--|----------|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RONALD LEE LAMARR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 3. SEX M | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 10 13 55 | | 6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 9 15 1982 | | 2d. HOUR 1:50 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROUTE 495 - AT CEDAR LAKE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY MANAGER | | | | 12b. KIND OF BUSINESS OR INDUSTRY TH MANDY | | | | | | | |
| 13a. STATE MD | | | | | | | | | | 13b. CITY OR TOWN PRINCE GEORGE | | 13c. CITY OR TOWN MYRTLE VILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS STN 36A AVE 20782 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST OTCHELL L. LAMARR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THELMA G. TONEY | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 1977-1980 | | 17. INFORMANT OTCHELL L. LAMARR | | ADDRESS SAME AS 13 FATHER | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8159 MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 1:50 PM 9 15 1982 | | | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 1:50 PM 9 15 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) MOTORCYCLE HIT GUARD RAIL | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ROAD | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 495 - AT CEDAR LAKE BETHESDA MONT MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle M.D. | | | | | | | | | | TITLE (SPECIFY) DEPT | | MEDICAL EXAMINER | | DATE SIGNED 9/15/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE | | | | | | | | | | ADDRESS 8200 WISCONSIN AVE BETHESDA MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PRI GEO MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 2 0

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|--|---|-------------------------------|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOIS BEATRICE LAMPRECHT | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 25, 1982 | | 2b. HOUR 10:30 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Bethesda, Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Bookbinding | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Ohio Lucas | | 13c. CITY OR TOWN Toledo | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4676 Violet Road lot 11 43623 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Wojciechowski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Reiter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 295-24-2086 | | 17. INFORMANT George A. Lamprecht (husband) | | | ADDRESS same | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) Bleeding and Sepsis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoma | | 8 Years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Anemia, Thrombocytopenia, Uremia, Hypercalcemia

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22. I certify that (X) (this hospital) attended the deceased from **August 10, 1982** to **September 25, 1982** that **X** (we) lost the deceased alive on **September 25, 1982**, and that in **our** (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.

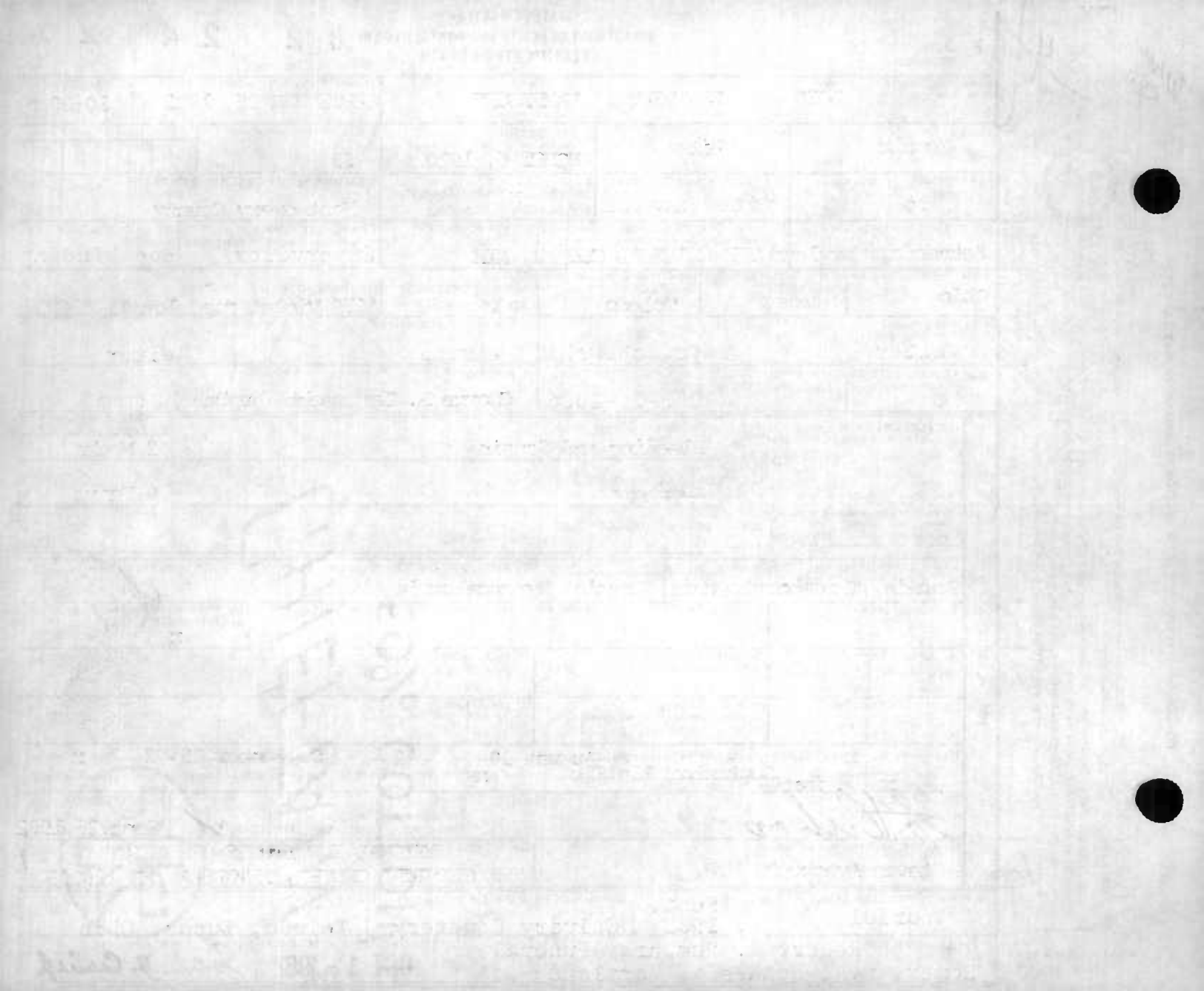
| | | | | | |
|---|--|--|--|---|--|
| 22a. SIGNATURE Steven Averbuch MD | | DEGREE | | 22c. DATE SIGNED Sept. 26, 1982 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Averbuch, M.D. | | 22d. ADDRESS NATIONAL INSTITUTES OF HEALTH THE CLINICAL CENTER, BETHESDA, MD 20205 | | | |

| | | | | | | | |
|--|--|------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Toledo, Lucas, Ohio | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphyre Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canick | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

22a

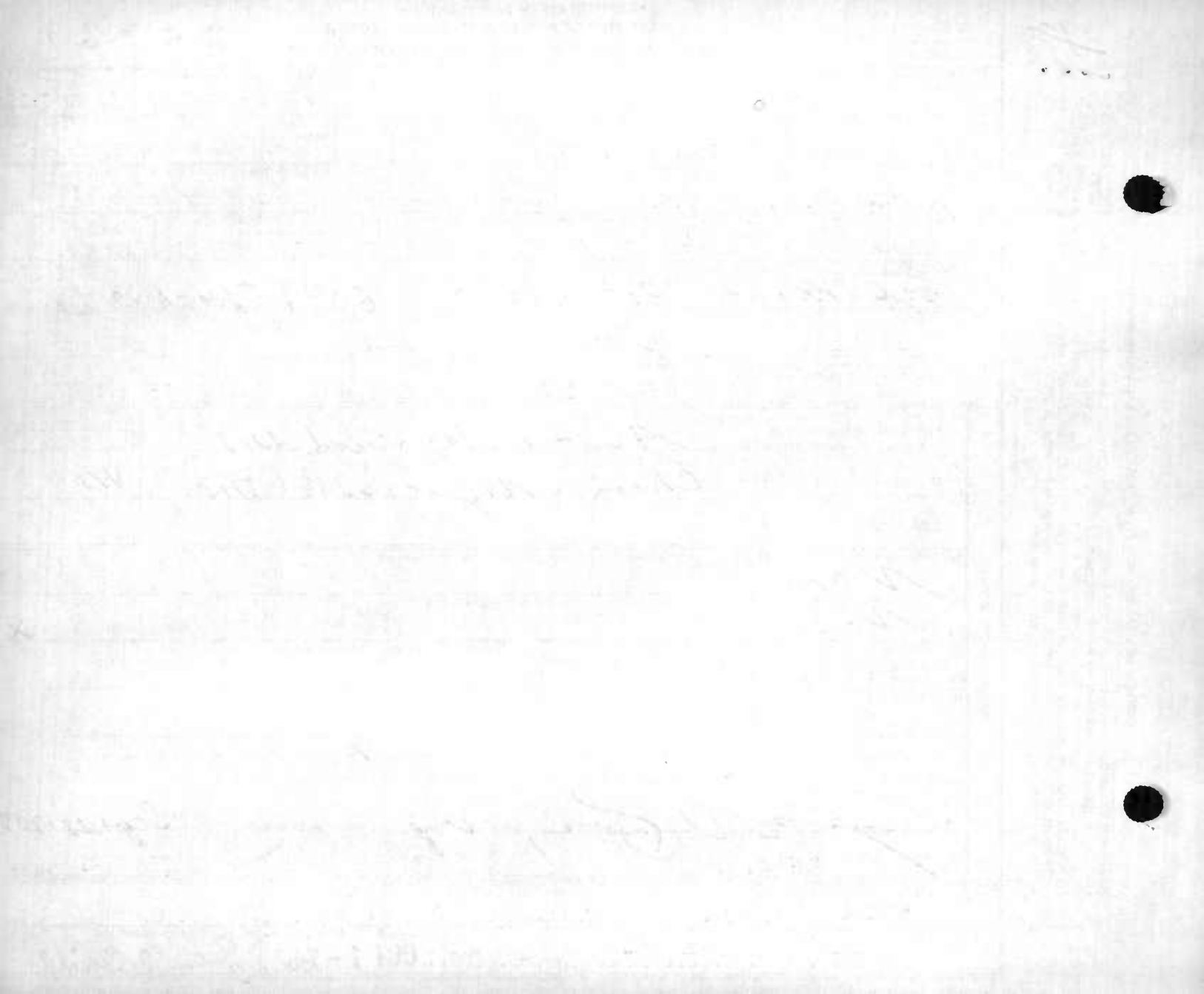


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A 15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24121 | | | |
|---|--|-----------------|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2b. DATE KNOWN OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albion G. Langley | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED 9/25/82 | | | |
| 3. SEX male | | 4. RACE cauc | | 5. DATE OF BIRTH DEC 15, 1900 | | 6. AGE (IN YEARS) 81 YRS. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 9/25/82 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT DHE ELECTRIC CO. | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | 12c. DATE KNOWN OF DEATH | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6037 Cherokee Dr 20814 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES LANGLEY | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE MCSHEA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 578-09-3272 | | 17. INFORMANT MARY S. DRAKE | | | | ADDRESS SAME AS 13 DAUGHTER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Inf.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Inf.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4291 Yrs. | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION None | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | TITLE (SPECIFY) M.D. Day | | MEDICAL EXAMINER DATE SIGNED 9/25/82 | |
| ACTUAL SIGNATURE JOHN S. ROGERS | | | | EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS | | | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C. | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 1 2 2 | |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) OPAL MAE LASKO | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29 1982 | | 7b. HOUR 4:18 p.m. | | | |
| 3 SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 7 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN DERWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7430 NEEDWOOD ROAD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BETHEL CLAUDE ZUMBRO | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE MAUD NILES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 442-12-5565 | | 17. INFORMANT ADDRESS MICHAEL J. LASKO, 7430 NEEDWOOD ROAD, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 27, 19 82 to SEPTEMBER 29, 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 29, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dennis L. Azuma LTM C | | | | | | DEGREE MEDICAL | | 22c. DATE SIGNED 30 Sep 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS L. AZUMA, LT, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MARYLAND 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (SPECIFY) Burial | | 23b. DATE Oct. 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va. | | | | | |
| 24. FUNERAL DIRECTOR Francis H. Barber | | | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canier | | | | | |

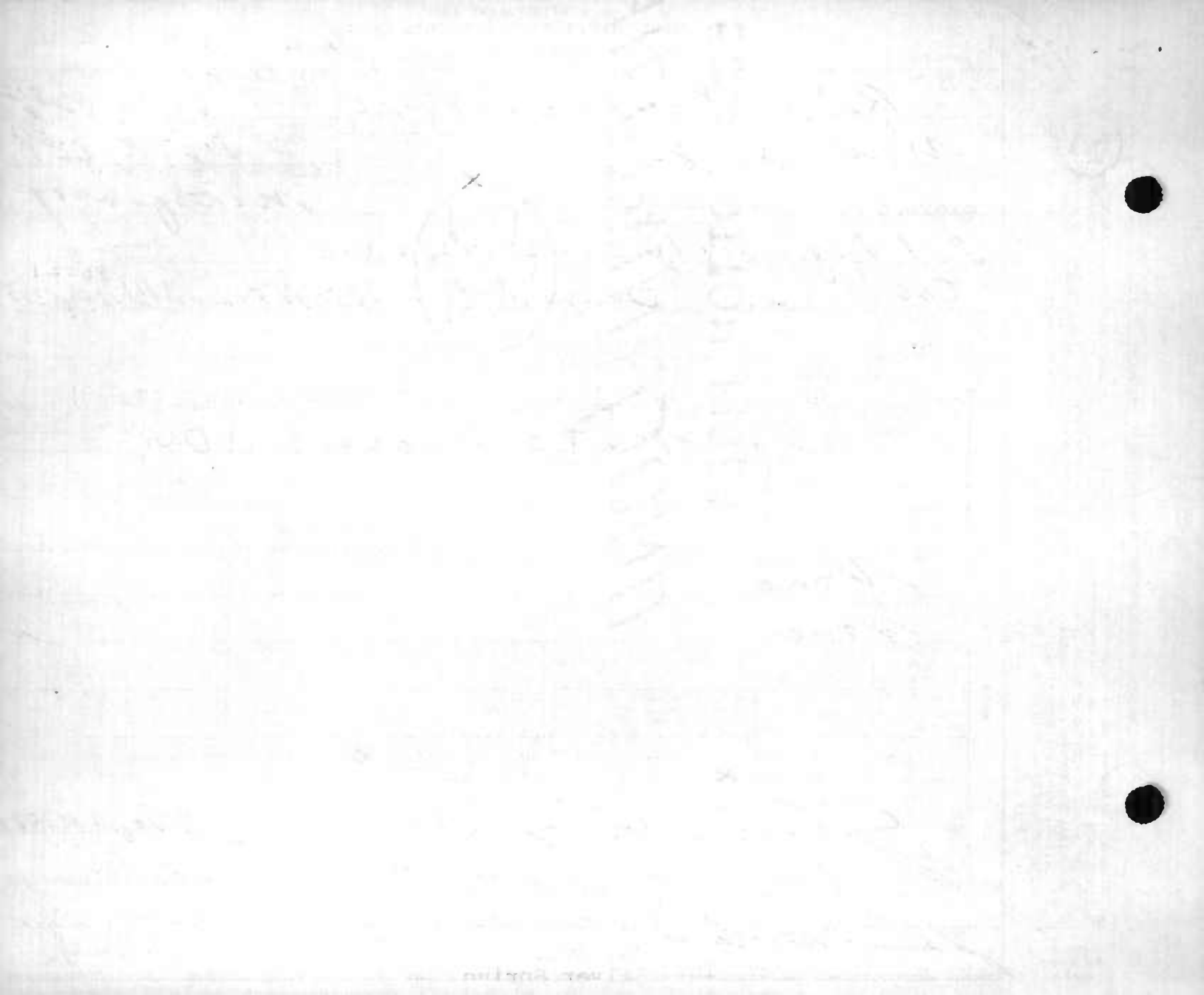
5102

1990

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 4 1 2 3 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ralph Stanley Lawrence | | | | | | | | | | 2a. DATE KNOWN OF DEATH Sept 16, 1982 | |
| 2b. HOUR 5:12 | | | | | | | | | | 2c. DATE PRONOUNCED DEAD Sept 16, 1982 | |
| 3. SEX M | | | | | | | | | | 4. RACE W | |
| 5. DATE OF BIRTH Mar 28, 1960 | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U S America | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH St. Louis | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MSgt | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY US Army | |
| 13a. STATE CO | | | | | | | | | | 13b. COUNTY Adams | |
| 13c. CITY OR TOWN Denver | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES | |
| 14. FATHER'S NAME (TYPE OR PRINT) Arthur Laurence | | | | | | | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. 2292 18 1324 | |
| 17. INFORMANT (TYPE OR PRINT) Eleanor Laurence | | | | | | | | | | 17. ADDRESS (same as #13) 80221 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? NO | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. Dep. MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED Sept 18, 1982 | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, D. M. E. | | | | | | | | | | ADDRESS Silver Spring, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 9-20-82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Logan Nat'l. Cem. | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Denver Colo. | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 23 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 2 4 | | | |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| WILLIAM LAVINE | | | | 09/19/82 10:55 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | Oct. 2, 1904 | | 78 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Boston, Mass. | | U.S.A. | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Hebrew Home of Greater Washington | | Clerk | | Liquor Store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| D.C. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| Harry | | | | Fannie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| Yes | | | | Coast Guard 578-10-8693A | | | |
| 17. INFORMANT | | | | Rockville, Maryland | | | |
| | | | | Hebrew Home of Greater Wash.; 6121 Montrose Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4850 IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA | | | | | | | 1 WEEK |
| DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN ETIOLOGY | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | CITY OR TOWN STREET COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/91 to 9/19/82 and that in (my) (our) opinion death occurred on this date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| D. D. Patel | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 9/20/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| D. D. Patel | | 6121 MONTROSE RD. ROCKVILLE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 9/23/82 | | Chesed Shel Emes | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | SEP 27 1982 | | J. Smith | | | |
| 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | | | |

BP



CP/1/1/10

LAINE

WILLIAM

MONTAGNEY

INDEX

BRITISH INDIAN

GENERAL SERVICE

RECEIVED

X



CP/1/1/10
1/1/10
1/1/10

1/1/10
1/1/10

1/1/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 4 | 1 | 2 | 5 | | | |
|--|--|--|--|--|--|--|---|---|--|--|---|---|---|---|---|--|--|--|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a DATE OF DEATH | | | | | | | | | |
| FIRST MIDDLE LAST ROBERT B. LAWSON, Sr. | | | | | | | | | | MONTH 9 | | DAY 22 | | YEAR 82 | | 2b HOUR 7:22 P M | | | |
| 3 SEX MALE | | | 4 RACE WHITE | | | 5 DATE OF BIRTH MONTH DAY YEAR 9 27 1900 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. DC USA | | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Silver Spring | | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hsopital | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Railroad | | | 12b KIND OF BUSINESS OR INDUSTRY Terminal Co. | | | | | | |
| 13a STATE Maryland | | | | | | | | | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Silver Spring | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 2603 Avena Street 20902 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George C. Lawson | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Martin | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b SOCIAL SECURITY NO. 718-18-0298 | | | | | 17 INFORMANT Ray J. Lawson ADDRESS Wife Same as 13 | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease with Arrhythmia 4149 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a I certify that (this hospital) attended the deceased from 9-22 , 19 80 , to 9-22 , 19 82 that (we) last saw the deceased alive on 9-22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE B B Cushner, MD | | | | | | | | | | DEGREE | | 22c DATE SIGNED 9-23/82 | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Gilbert + Cushner | | | | | | | | | | 22e ADDRESS 1116 New Hampshire Ave S.S. Md. | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b DATE Sep. 25, 1982 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | | | | | ADDRESS 500 University Blvd., W. Silver Spring, Md. | | 25a DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b REGISTRAR'S SIGNATURE <i>John J. [Signature]</i> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove card No. 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked as (b) (1) or (b) (2), the medical examiner, or other appropriate official, must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 8 2 2 4 1 2 6 | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Vola -- Leary | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 13, 1982 | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 10 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | 2b. HOUR 145/p.m. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY Md. Mont | | | | | 13b. CITY OR TOWN Silver Spring | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2101 Fairland Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. Williams Chaney | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Marsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 579-38-5219 T | | 17. INFORMANT ADDRESS Carlton Adams. 2 024 Spottswood Rd., Charlottesville Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 yrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 15 1982 to 9/13 1982 , that (I) (we) last saw the deceased alive on Aug 15 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Joseph Wallace | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/13/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Wallace | | | | | 22e. ADDRESS 5817 Lenox Rd. Kenwood Park, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9/15/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | | | 25a. FILED BY REGISTRAR SEP 21 1982 | | | | | |

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|---------------|---------------|-----------------------|--------------------|
| Female | White | Apr. 10 1882 | 27 |
| Wash., D.C. | U.S.A. | xx | contrary |
| Silver Spring | Robertson | Howe | Home |
| Mont | Silver Spring | 2101 E. Highland Road | |
| J. Williams | James Cheney | Cherry Hill | |
| --- | 570-38-219 T | Clinton | 2024 Spottwood Rd. |

Joseph Wallace
 5817 Lenox Rd.
 Norwood, Ark., Bethesda, Md.

5/15/1982 Cedar Hill Cemetery
 Joseph Wallace's home Inc.
 2100 Rice Ave., N.W. Wash., D.C.

Withland, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 2 7 REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) MARY ATKINSON LEE | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20 1982 | | | | 2b. HOUR 4:00 a.m. | | | |
| 1. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 16 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR HOME | |
| 13a. STATE VIRGINIA | | 13b. COUNTY FAIRFAX | | 13c. CITY OR TOWN MCLEAN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM EDWARD ATKINSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE FAY UTTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 263-26-5131 | | 17. INFORMANT ADDRESS NORMAN I. LEE, JR., 1612 SIMMONS DRIVE | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 1749 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic breast carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 12 1982 to SEPTEMBER 20 1982 , that (I) (we) lost saw the deceased alive on SEPTEMBER 20 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Marion R. McMillan</i> | | DEGREE MD | | 22c. DATE SIGNED 20 SEPTEMBER '82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARION R. MCMILLAN, LT, MC, USNR | |
| 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Sept. 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Maysville Cemetery | | 23d. LOCATION CITY OR TOWN STATE Maysville, Kentucky | |
| 24. FUNERAL DIRECTOR NAME Ives Funeral Home Arkington, Va. 22201 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Cabell</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 2 8 REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE JEFFERY LEE MAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 23, 1982 | | | |
| 3. SEX MALE | | | | 2b. HOUR 11:50 A.M. | | | |
| 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1957 | | 6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer | | 12b. KIND OF BUSINESS OR INDUSTRY Mariott Corp. | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Takoma Park | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Leeman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN No | | 16b. SOCIAL SECURITY NO. 192 52 6808 | | 17. INFORMANT ADDRESS Beverly M. Leeman Same as #13 (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED THORACIC AORTIC ANEURYSM (or Chosen/duy) 4411 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 18, 1982 , to Sept. 23, 1982 , that (I) (we) lost saw the deceased alive on Sept. 23, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard Chasen M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD CHASEN, M.D. | | | | 22e. ADDRESS 1109 Spring Street Silver Spring, Md 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE 9/28/82 | | 23c. NAME OF CEMETERY OR PLACE Greenwood Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lower Burrell Westmoreland Pa | |
| 24. FUNERAL HOME RECORDS NAME Francis Gasch's Sons Funeral Home, P.A. ADDRESS Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1982 | | 25b. REGISTRAR'S SIGNATURE Sam J. Connel | |

Unfused, collared, inv.

53/85/8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked with an "X", any injury, or other traumatic event, the medical examiner must be notified and the death certificate signed by a medical examiner.

Cleared by FRANCIS MAYLE, MEDICAL EXAMINER

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | 8 2 2 4 1 2 9 | |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) DAVID ALVIN LEMBERT | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13 1982 | | 2b. HOUR 1:05 P.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 27 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY PRIVATE | |
| 13a. STATE CALIFORNIA | | 13b. COUNTY ENCINO | | 13c. CITY OR TOWN ENCINO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME MORRIS LEMBERG | | 15. MOTHER'S MAIDEN NAME FRANCES LEMBERG | | 13e. STREET ADDRESS 5151 WHITE OAK AVENUE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1946 342-46-8279A | | 17. INFORMANT 4504 PETIT AVENUE NANCY GORDON, ENCINO, CALIFORNIA 91436 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF THE PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 1982 , to SEPTEMBER 13, 1982 , that (I) (we) lost saw the deceased alive on SEPTEMBER 13, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Louis Lemberg | | 22c. DATE SIGNED 9-13-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS LEMBERG, MD | | | |
| 22e. ADDRESS 3661 S. Miami Avenue, Miami, FL 33133 | | 22f. DATE SIGNED 9-13-82 | | | | 22g. SIGNATURE SEP 20 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (S) CREMATION | | 23b. DATE 9/16/1982 | | 23c. NAME OF CEMETERY OR INTERMENTARY LOS ANGELES ODDFELLOWS CEMETERY ASSOCIATION | | 23d. LOCATION CALIFORNIA LOS ANGELES, LOS ANGELES | |
| 24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | |

From Henry R. ...
28-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 1 3 0 | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Erminia C. Leonardo | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 5 82 | | 2b. HOUR 7:42 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS | | 7b. IF UNDER 24 HRS. HOURS MIN. 7 42 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. U.S. Govt. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN S.S. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8 Finebury Pk.Ct. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Enrico Leonardo | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vincenza Bronca | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW I | | | |
| 16b. SOCIAL SECURITY NO. 220-44-6592T | | | | 17. INFORMANT ADDRESS Ercole Leonardo-brother-Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1930 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of thyroid DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 82 , to 9/5 , 19 82 , that (I) (we) last saw the deceased alive on Sept. 5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL MD. | | | | 22c. ADDRESS 1811 Prince Philip Dr. Chevy Chase Md 20832 | | | | 22d. DATE SIGNED 9/5/82 | | 22e. DEGREE M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | 24b. ADDRESS 11800 N.H. Ave., S.S. Md. 20904 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph D. Livingston | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/25/82 | | | 2b. HOUR MIN. 11:11 A | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3/11/16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Warrant | | 12b. KIND OF BUSINESS OR INDUSTRY US Army | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rex E. Livingston | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Margaret McPherson | | 16. ADDRESS 700 Sligo Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 483-10-4326 | | 17. INFORMANT Mrs. Mae Livingston-Wife- Apt. 102, SS. Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxic encephalopathy 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Respiratory + circulatory (c) 1629 | | | | | | APPROXIMATE BETWEEN CROSSES 20910 1 W/K | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Carcinoma Right Lung | | | | | | | |
| 19a. DATE OF OPERATION 9/16/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma (R) Lung | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/25/82 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 3) | | | |
| 22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/25/82 | | 22c. LOCATION STREET CITY OR TOWN COUNTY STATE 9/25/82 | | | |
| 23. I certify that (i) this hospital attended the deceased from 9/25/82 to 9/25/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death. | | | | | | | |
| 24. SIGNATURE Barry J. Levin, MD | | 25. ADDRESS 4801 MASS AVE, N.W. WASH DC | | 26. DATE SIGNED 9/25/82 | | | |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 27b. DATE Sept 29, 1982 | | 27c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran Cemetery, Pine Grove, PA. | | 27d. LOCATION CITY OR TOWN COUNTY STATE | |
| 28. FUNERAL DIRECTOR NAME W W CHAMBERS CO., 8653 | | 28a. ADDRESS Ca., Ave. S. S. Md. | | 29. DATE REC'D. BY REGISTRAR 20910 2.9 1982 | | 30. REGISTRAR'S SIGNATURE John J. Conner | |

BP

Handwritten notes and stamps at the top of the page, including a date stamp "JAN 19 1964" and various illegible markings.

Main body of handwritten text, appearing to be a letter or report, with several lines of cursive script. The text is mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 2 4 1 3 2 | |
|--|--|--|--|--|---|--|----------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANE LORINCZI | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 - 1 - 82 | | 2b. HOUR 2:30 AM | | | | |
| 3 SEX Female | | 4 RACE Czechoslovakian | | 5. DATE OF BIRTH MONTH DAY YEAR 3 - 3 - 99 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | | | | |
| 10 CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Hebrew Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY OWN Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Montg | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6121 Montrose Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ignatius MNX SZENDE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Weichert | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT George Lorinczi | | ADDRESS 5108 Palisade Ln Wash D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DOE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DOE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1/82 , 19 82 , to 9/1/82 , 19 82 , that (I) (we) lost saw the deceased alive on 9/1/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ramleth T.A. Shakir | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/1/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMLETH T.A. SHAKIR | | | | 22e. ADDRESS 6121 Montrose RD Rockville MD 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cmty | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Montg Md | | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. Chambers | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND | | | | | | | | | | 2 | | 2 | | 4 | | 1 | | 3 | | 3 | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------------|--|---------------------------------------|--|--|--|--|--|---------------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 20. DATE KNOWN OF DEATH | | 21. DATE OF DEATH | | 22. DATE OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| Samuel Lubitz | | | | | | | | | | Sept 25 1982 | | Sept 25 1982 | | Sept 25 1982 | | Sept 25 1982 | | Sept 25 1982 | | Sept 25 1982 | | Sept 25 1982 | |
| 3. SEX | | | | | | | | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | 10. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | | | | | | | | | | White | | 5/11/27 | | 27 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 70. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 71. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. NEVER MARRIED | | 10. WIDOWED | | 11. DIVORCED | | 12. DATE PRONOUNCED DEAD | | 13. BALTIMORE CITY OR COUNTY OF DEATH | |
| Poland | | | | | | | | | | U. S. A. | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | Sept 26 1982 | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. DATE PRONOUNCED DEAD | | 15. BALTIMORE CITY OR COUNTY OF DEATH | | 16. DATE OF DEATH | | 17. DATE OF DEATH | |
| Sil. Spg. | | | | | | | | | | 1000 Brunswick Ave. | | Merchant | | Grocery | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | 13e. DATE PRONOUNCED DEAD | | 13f. BALTIMORE CITY OR COUNTY OF DEATH | | 13g. DATE OF DEATH | | 13h. DATE OF DEATH | |
| Md | | | | | | | | | | Mont. | | YES | | 1000 Brunswick Ave | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | 16. DATE PRONOUNCED DEAD | | 17. BALTIMORE CITY OR COUNTY OF DEATH | | 18. DATE OF DEATH | | 19. DATE OF DEATH | | 20. DATE OF DEATH | | 21. DATE OF DEATH | |
| Leon Lubitz | | | | | | | | | | Celia Meltzer | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | Sept 26 1982 | | Sept 26 1982 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | 19. DATE PRONOUNCED DEAD | | 20. BALTIMORE CITY OR COUNTY OF DEATH | | 21. DATE OF DEATH | | 22. DATE OF DEATH | |
| Yes | | | | | | | | | | 577-10-7809-A | | Mrs. Evelyn E. Lubitz | | 2601 Bel Pre Road, Silver Spring, Md | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20. DATE PRONOUNCED DEAD | | 21. BALTIMORE CITY OR COUNTY OF DEATH | | 22. DATE OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| 4291 IMMEDIATE CAUSE (a) | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| Acute Myocardial Dis | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| (b) Chronic Myocardial Dis | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| (c) | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| None | | | | | | | | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | | 26. DATE OF DEATH | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21. DATE PRONOUNCED DEAD | | 22. BALTIMORE CITY OR COUNTY OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | | 25. DATE OF DEATH | |
| None | | | | | | | | | | | | YES | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | Sept 26 1982 | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. LOCATION | | 21e. PLACE OF INJURY | | 21f. DATE PRONOUNCED DEAD | | 21g. BALTIMORE CITY OR COUNTY OF DEATH | | 21h. DATE OF DEATH | |
| WHILE AT WORK | | | | | | | | | | P.M. | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | STREET | | STREET, FACTORY, FARM, ETC.) | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | Autopsy | | Inspection | | Inquiry | | and in my opinion | | 21f. DATE PRONOUNCED DEAD | | 21g. BALTIMORE CITY OR COUNTY OF DEATH | | 21h. DATE OF DEATH | |
| Natural causes | | | | | | | | | | Accident | | Suicide | | Homicide | | Undetermined manner | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE PRONOUNCED DEAD | | 23f. BALTIMORE CITY OR COUNTY OF DEATH | | 23g. DATE OF DEATH | | 23h. DATE OF DEATH | |
| Burial | | | | | | | | | | 9/28/1982 | | King David Mem. Garden | | Falls Church, Virginia | | Sept 26 1982 | | Montgomery MD. | | Sept 26 1982 | | | |
| 24a. DIRECTOR | | | | | | | | | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION | | 24e. DATE PRONOUNCED DEAD | | 24f. BALTIMORE CITY OR COUNTY OF DEATH | | 24g. DATE OF DEATH | | 24h. DATE OF DEATH | |
| 252 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | SEP 29 1982 | | SEP 29 1982 | | SEP 29 1982 | | SEP 29 1982 | | SEP 29 1982 | | SEP 29 1982 | | SEP 29 1982 | |

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M. D.

ADDRESS

1919 Seminary Road, Silver Spring, Md.

TITLE (SPECIFY)

M.D. Dep.

MEDICAL EXAMINER

DATE SIGNED

Sept 26 1982



MAILED
OCT 10 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH MONTH DAY YEAR 9/20/82 | | 2b. HOUR 2 A. M. | |
| 1. DECEASED NAME (TYPE OR PRINT) SAMPSON SAMPSON | | MIDDLE LIFTIG | | LAST LIFTIG | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 15, 1899 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HEBREW HOME OF GREATER WASHINGTON | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) SPORTSWEAR | | 12b. KIND OF BUSINESS OR INDUSTRY CLOTHING | | 13. STREET ADDRESS 6121 MONTROSE ROAD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MORRIS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE FLICK | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | |
| 17. SOCIAL SECURITY NO. 11 | | 18. INFORMANT CHARLOTTE CHAIKEN | | 19. ADDRESS 26 STRAWBERRY HILL AVE. STAMFORD, CONNECTICUT | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE DEMENTIA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/30/81 to 9/20/82 that (I) (we) last saw the deceased alive on 9/20/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D. D. PATEL | | DEGREE M.D. | | 22c. DATE SIGNED 9/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL | | 22e. ADDRESS 6121 MONTROSE RD. ROCKVILLE MD. | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SEE #17) BURIAL | | 23b. DATE 9/21/1982 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN | |
| 23d. LOCATION CITY OR TOWN FALLS CHURCH, VIRGINIA | | 23e. NAME OF CEMETERY OR CREMATORY | | 23f. LOCATION | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25. DATE REC'D. BY REGISTRAR SEP 23 1982 | | 26. REGISTRAR'S SIGNATURE John J. Lankford | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 3 5

REG. NO.

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) OLIVIA C. MADDOX | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 9, 1982 | | 2b. HOUR 4:15 M | |
| 3 SEX Female | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10 CITY OR TOWN OF DEATH Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Clerk | | 12b. INDUSTRY OF BUSINESS OR INDUSTRY Government |
| 13a. USUAL RESIDENCE (IF IN HOSPITAL, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20906 | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME 14a. FIRST William | | 14b. MIDDLE C. | 14c. LAST Well | | 15. MOTHER'S MAIDEN NAME 15a. FIRST Betty |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214 52 6085 | | 17 INFORMANT ADDRESS Louise H. Maddox Same as #13 (Daughter) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Senescent arteriosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 1977 to Sept 9, 1982 , that (I) (we) lost saw the deceased alive on 8-31-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Boris Rabin, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9-9-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS RABKIN, M.D. | | 22e. ADDRESS 1019 Univ. Blvd. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | |
| 23d. LOCATION CITY OR TOWN Brentwood | | COUNTY P.G. | | STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME Frazer's Gasch's Sons Funeral Home, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | |
| ADDRESS Hyattsville, Maryland | | | | 25b. REGISTRAR'S SIGNATURE J. J. Carver | |

BP



OL 11-1714

Row 1 - C. 11-1714

Government

1000 Washington Lane

William C. Kelly

No. 1000 Montgomery Silver Spring X

1014 20 0087 Louise H. Naborz

1014 20 0087 Louise H. Naborz

1014 20 0087 Louise H. Naborz

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30x1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

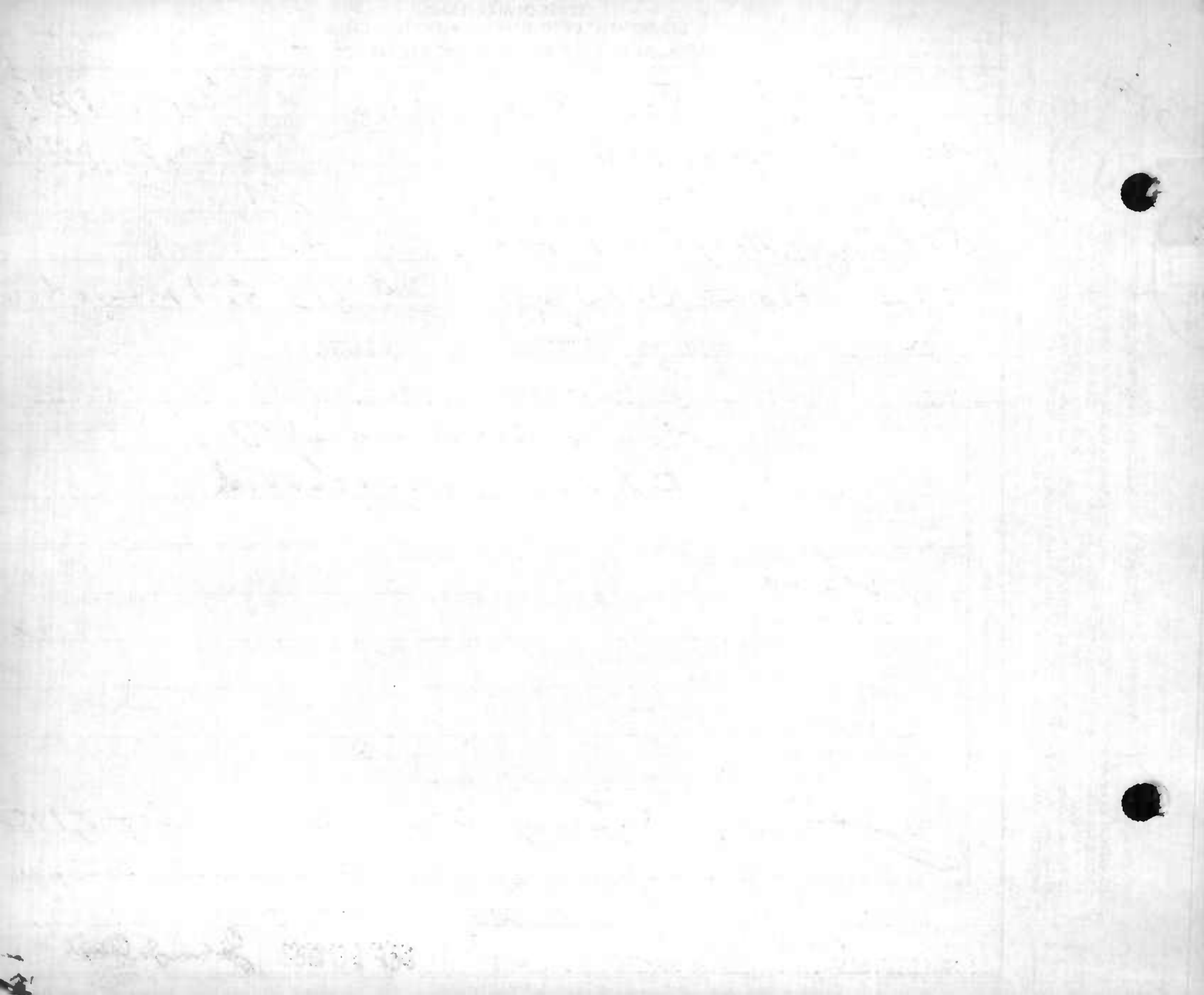
BP _____

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

82 24136
REG. NO.

| | | | | | | | |
|---|---------|--|------------------------------------|--|---------------------|---|--------------------------|
| 1. FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH ESTIMATED | | 21. MONTH DAY YEAR | | 22. HOUR MIN. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. FIRST | | 3. MIDDLE | | 4. LAST | |
| Joseph | | J. | | Magnolia | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 10. MONTH DAY YEAR |
| M | W | Sept 6 1961 | 26 | | | Sept 5 1982 | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. BALTIMORE CITY OR COUNTY OF DEATH | |
| WASHINGTON, D. C. | | U.S.A. | | | | MONTGOMERY | |
| 15. CITY OR TOWN OF DEATH | | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 18. KIND OF BUSINESS OR INDUSTRY | |
| St. Louis | | Holy Cross Hosp. | | PLUMBING CONTRACTOR | | | |
| 19. USUAL RESIDENCE (IF INSURING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 20. STATE | | 21. CITY OR TOWN | | 22. INSIDE CITY LIMITS? | |
| Montgomery | | MD | | Silver Spring | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 23. FATHER'S NAME FIRST MIDDLE LAST | | 24. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 25. STREET ADDRESS | | 26. CITY OR TOWN | |
| DOMINICK GIOVANNI | | MAGNOLIA NUNZIATA | | 813 Silver Spring Ave | | 20901 | |
| 27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 28. SOCIAL SECURITY NO. | | 29. INFORMANT | | 30. ADDRESS | |
| YES | | WW II | | 579-03-7649 | | VIRGINIA H. MAGNOLIA SAME AS 13 WIFE | |
| 31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dist</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>Chronic Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| None | | | | | | | |
| 33. DATE OF OPERATION | | 34. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 35. AUTOPSY? | |
| None | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 36. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 37. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 38. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | |
| John S. Rogers M.D. | | Medical Examiner | | | | Sept 5, 1982 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | 1919 SEMINARY ROAD, SILVER SPRING, MD. | |
| JOHN S. ROGERS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 9/8/82 | | GATE OF HEAVEN | | SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR NAME | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | SEP 10 1982 | | John J. Collins | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 3 7 | | | |
|---|--|--|--|---|--|---|--|
| 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Rosemary B. Maher | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 9, 1982 | | 2b. HOUR 12 M PM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5817 Greenlawn Drive | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Public School | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13e. STREET ADDRESS 5817 Greenlawn Drive 20814 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Timothy Bannigan | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary R. Walsh | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-58-3919 | | 17. INFORMANT Thomas F. Maher same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1541 Metastatic Rectal Carcinoma IMMEDIATE CAUSE (a) Rectal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Rectal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Rectal Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months 8 months | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 20, 1982 to 9 Sept. 1982 , that (I) (we) last saw the deceased alive on 9 Sept. 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. Phibbe MD | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-10-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBBE MD | | | | 22e. ADDRESS 16400 Connecticut Ave Kensington MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

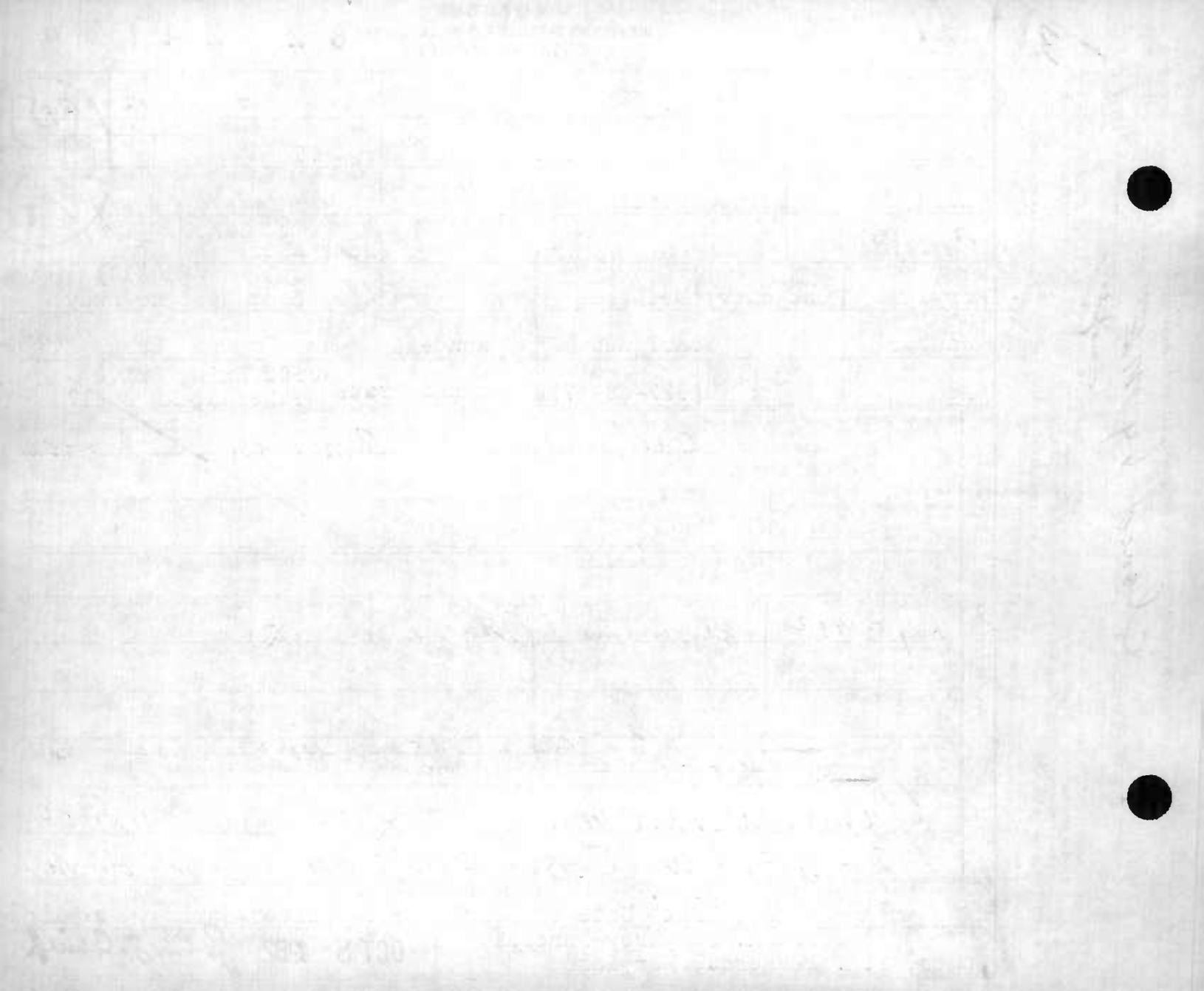
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 4 1 3 8 REG. NO. | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elia R. Martinez | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 27 82 | | 2b. HOUR 2 p.m. |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Montgomery | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS (20814) 4521 East West Highway | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jaspar Rodriguez | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Araceli Casas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 577-68-1779 | | 17. INFORMANT ADDRESS 8502 Ewing Drive Mariana Prats Bethesda, MD 20817 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION Aug 5-1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Pancreas | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>Aug 2</u> , 19 <u>82</u> , to <u>Sept 27</u> , 19 <u>82</u> , that (I) <u>was</u> last saw the deceased alive on <u>Sept 27</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, <u>that (I) did not</u> view the body after death. | | | | | |
| 22b. SIGNATURE James W. Egan M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN | | 22e. ADDRESS 5413 Cedar Ln. - Bethesda Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | 23e. DATE REC'D BY REGISTRAR OCT 5 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | 25a. REGISTRAR'S SIGNATURE John J. Conish | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

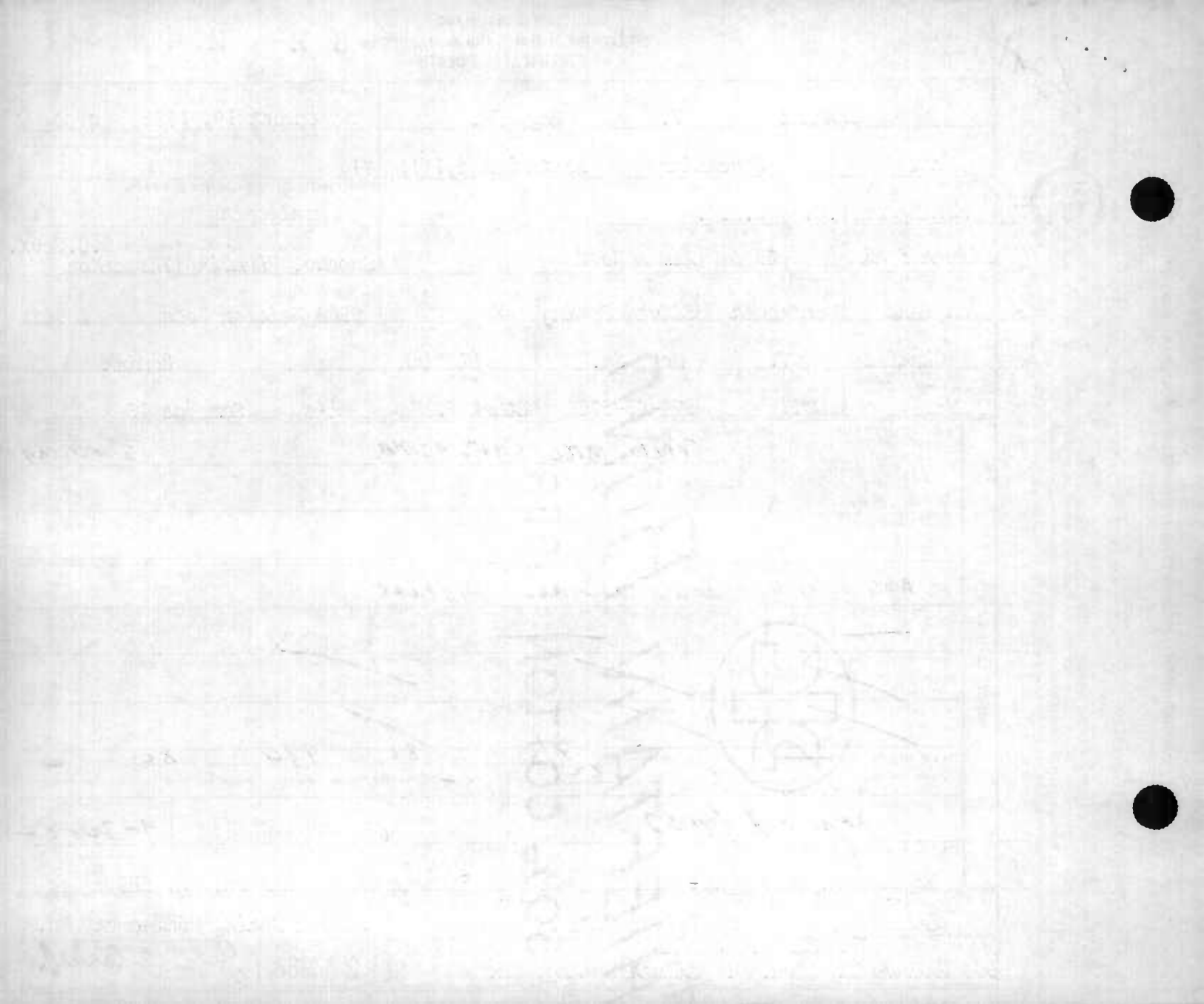
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|---|--|--|---|---|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles T. May, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 19, 1982 | | | 2b. HOUR 4:00 A M | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR September 2, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2506 Weisman Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superv. Plumbing | | 12b. KIND OF BUSINESS OR INDUSTRY D.C. Govt. Inspector | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles T. May, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Hunter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-05-5729 | | 17. INFORMANT Ethel F. May | | | ADDRESS Wife Same as 13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Metastatic Carcinoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) Atherosclerotic Cardiovascular Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION 8/5 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 8/5 | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/5 to 9/9 19 82 , that (I) (we) last saw the deceased alive on 9/9 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Raymond Bass | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-20-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond A. Bass, M.D. | | | | | | 22e. ADDRESS 3929 Ferrara Drive Wheaton, Md. 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 4 0 | | | |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES LEO MCANENY | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1982 | | 2b. HOUR 10:34am | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR November 28, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Physician | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN New Jersey Cape May Cape May | | | | 13e. STREET ADDRESS 1041 Cape May Avenue 08204 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James L. McAneny | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Keenan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII 182-36-2645 | | 17. INFORMANT ADDRESS Mrs. Sara McAneny (wife) Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1980 IMMEDIATE CAUSE (a) <u>Cervical cord and brainstem compression</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervical chordoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 15, 19 82</u> , to <u>September 21, 19 82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 21, 19 82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE T. Sanchez M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. SANCHEZ, M.D. | | | | 22e. ADDRESS The Clinical Center, NIH, 9000 Rockville Pike, Bethesda, Md. 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 25 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cape May Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cape May New Jersey | |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

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DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

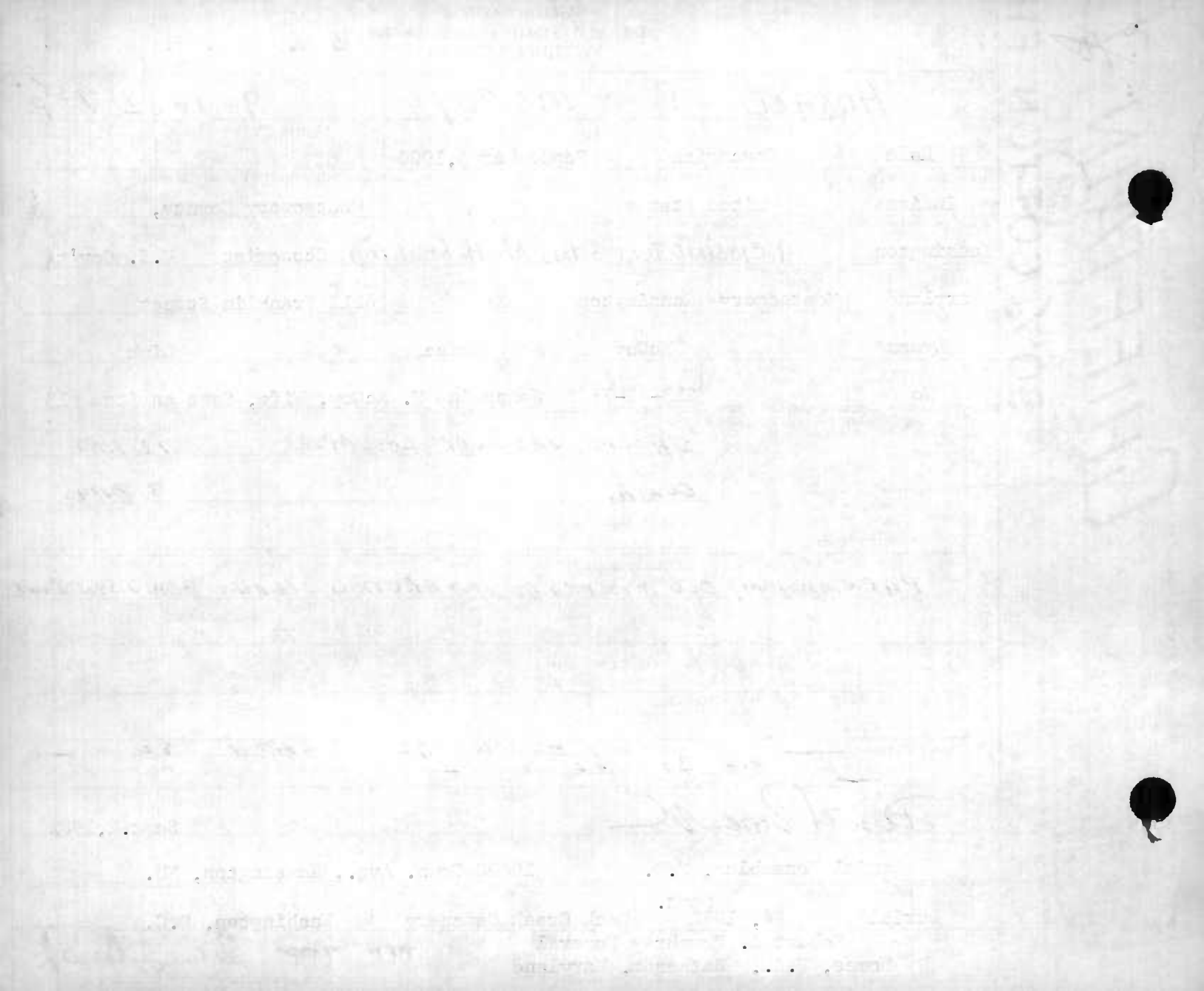
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|-----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes B. McBride | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-2-82 | | 2b. HOUR 10 ⁴⁵ P.M. | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 15, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH KENSINGTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSPITAL AIDE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PATRICK R. DALTON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HURTON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 027-18-8021 | | 17. INFORMANT ADDRESS PHILIP J. McBRIDE SAME AS 13 SON | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY ARTERY DISEASE</u> DOE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>recurrent urinary tract infection -</u> | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A. | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOW? MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>82</u> to <u>9/2</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>9/2</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph M. Solinas</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS MD | | | | | 22e. ADDRESS 9801 GEORGIA AV. S.S. MD. 20902 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD. | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | |
| SEP 8 1982 <u>John J. Connel</u> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 4 2 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST MIDDLE LAST HORACE B MCCOY | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-1-82 | | | |
| 3. SEX Male | | | | 2b. HOUR 7:35 PM | | | |
| 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR September 5, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | 7b. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON Gdms N. H. KEN MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | | |
| 13c. CITY OR TOWN Kensington | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lyman McCoy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luise Link | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-42-7869 | | | |
| 17. INFORMANT ADDRESS Jessamine T. McCoy, Wife, Same as item #13 | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3320 SHOCK, VASCULAR COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) COMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 3 DAYS | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. PARKINSONISM, OLD MYOCARDIAL INFARCTION, ORGANIC BRAIN SYNDROME | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 1972</u> to <u>Sept 1, 1982</u> , that (I) (we) last saw the deceased alive on <u>Aug 30, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Daniel Rosenblum | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 2, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Rosenblum, M.D. | | | | 22e. ADDRESS 10400 Conn. Ave., Kensington, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D BY REGISTRAR SEP 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |



Item 13e per phone 10/8/82 dad

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 2 4 1 4 3

| | | | | | | |
|--|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Percy M. McCracken | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-30-82 | | 2b. HOUR MIN. 6:54 P. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 7 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 75 YRS. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | 13c. CITY OR TOWN HYATTSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6204 43rd Avenue |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE MILLARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS MCCRACKEN FUNERAL HOME | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: 1950 IMMEDIATE CAUSE (a) Adenocarcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/29/82 to 9/30/82 , that (I) (we) last saw the deceased alive on 9/29/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED 10/1/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA | | 22e. ADDRESS 4404 Queensbury Rd. Riverdale | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Mahappay Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Mahappay Montgomery Penna | | 23e. DATE REC'D. BY REGISTRAR OCT 4 1982 | | | | |
| 24. FUNERAL DIRECTOR NAME Takoma Funeral Home, 251 Carroll St NW | | 24b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

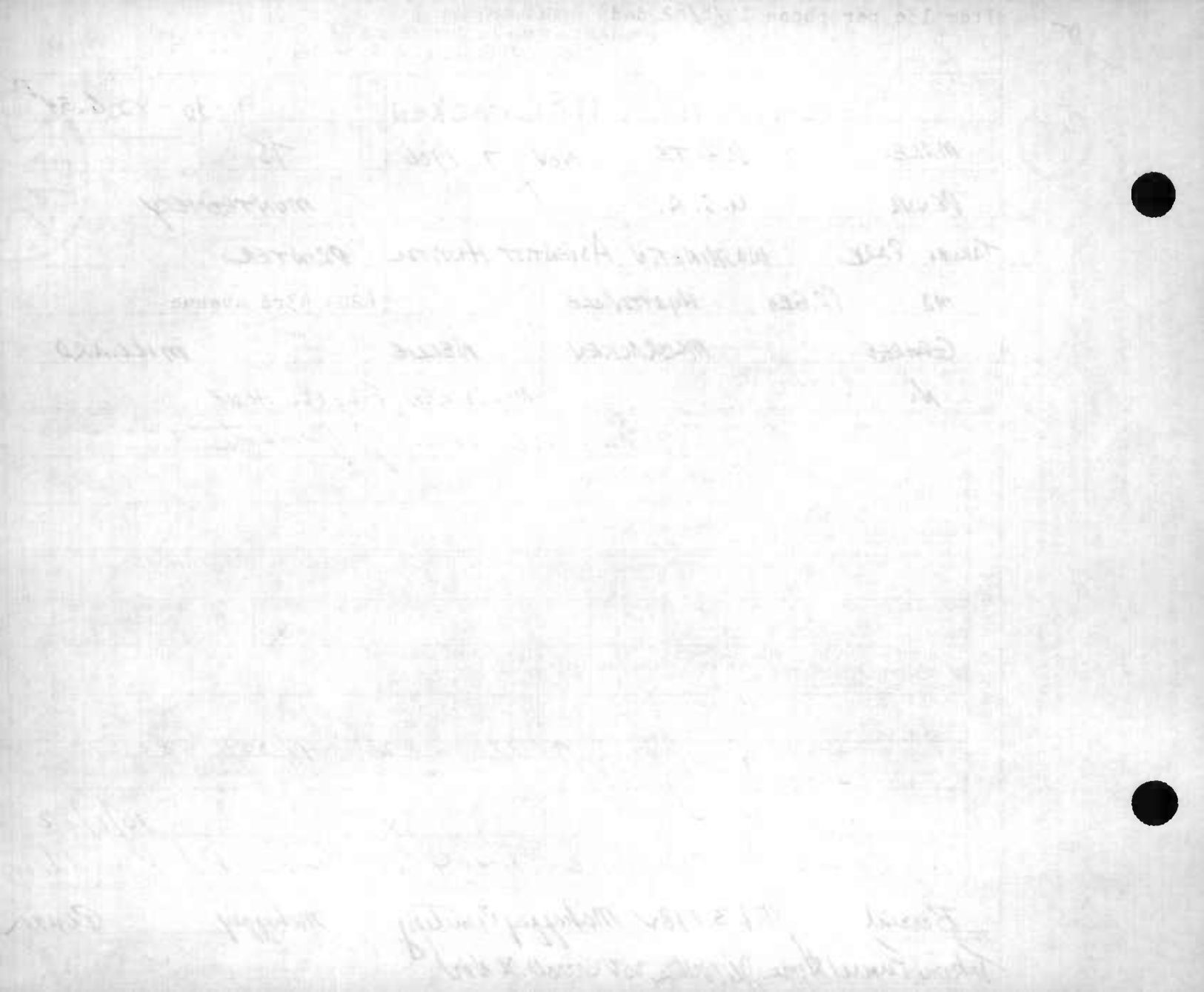
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DHMH 16-50M 1/81
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 9 25 82 | | 9:40 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | June 17 1901 | | 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Montana | | United States | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Shady Grove Adventist Hospital | | Attorney | | Private Law Practice | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Montgomery | | Gaithersburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 17811 Buehler Drive | | | |
| Michael P. McInerney | | Ann Moyer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | N/A | | John S. McInerney (Son) | | 17811 Buehler Drive | |
| | | 220-38-1416 | | Olney, Maryland | | 20832 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma - intraabdominal - possibly pancreatic</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| <u>pos. carcinoma of stomach</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/25/82</u> , 19 <u>82</u> , to <u>9/25/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/25/82</u> , 19 <u>82</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| <u>Sanford N. Richman, M.D.</u> | | | | Sanford N. Richman | | 11500 Old Georgetown Rd. Rockville, Md. 20852. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | September 28, 1982 | | St. Mary's Cemetery | | Rockville, Montgomery, Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | OCT 1 - 1982 | | John J. Lohr | | | |
| Robert A. Pumphrey Funeral Homes, PA | | | | | | | |

MEDICAL CERTIFICATION

1000-2000 1000-2000 1000-2000 1000-2000 1000-2000

1000-2000 1000-2000 1000-2000 1000-2000 1000-2000

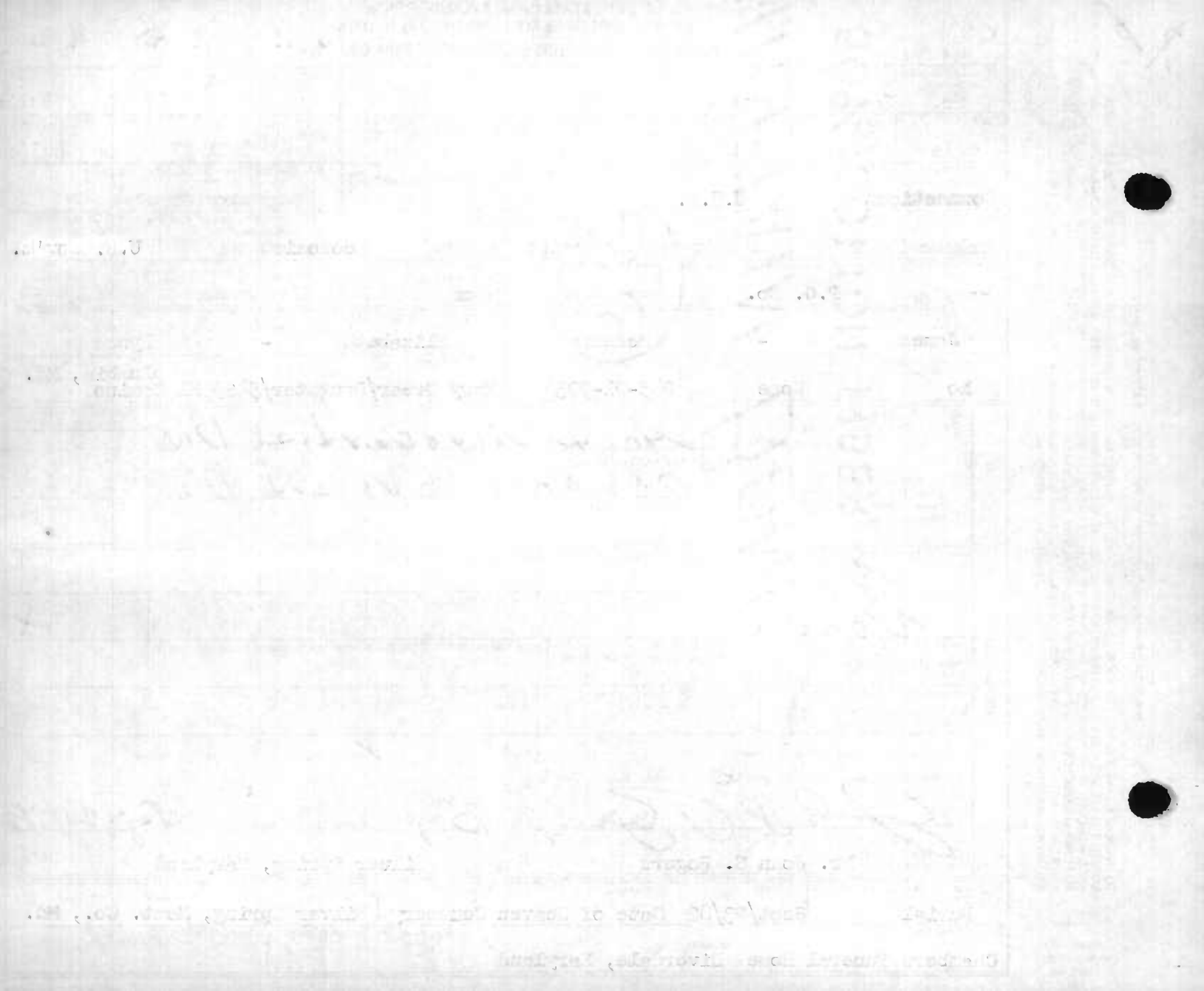
1000-2000 1000-2000 1000-2000 1000-2000 1000-2000

1000-2000 1000-2000 1000-2000 1000-2000 1000-2000

1000-2000 1000-2000 1000-2000 1000-2000 1000-2000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 1 4 5 | |
|---|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mr. Joseph Maurice McKenna | | | | | | | | | | 20. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 9 21 82, 9:12 AM | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 5 24 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 69 YRS. | | 7c. DATE PRONOUNCED DEAD 9 21 82 19 9:12 AM | | 2d HOUR | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH Takoma Pk Md | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN P.G. Co. | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James - McKenna | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - Lynch | | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 045-01-9938 | | | | 17. INFORMANT ADDRESS Mary Grear/Daughter/5429 El Camino, Columbia, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Myocard Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u> | |
| 19a. DATE OF OPERATION <u>None</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER | |
| ACTUAL SIGNATURE <u>Dr. John S. Rogers</u> | | | | | | | | | | DATE SIGNED <u>Sept 21/1982</u> | |
| EXAMINER'S NAME (TYPE OR PRINT) Dr. John S. Rogers | | | | | | | | | | ADDRESS Silver Spring, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept/23/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | |
| 23d. LOCATION CITY OR TOWN Silver Spring | | | | 23e. COUNTY Mont. Co., | | | | 23f. STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | | | | | | | ADDRESS Riverdale, Maryland | |



2071

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 2 | 2 | 4 | 1 | 4 | 6 |
|---|--|--|--|--|--|---|--|---|---|---|---|--|---|----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ISADOR WILLIAM MENDELSON | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14 1982 | | | | 2b. HOUR 3:30 PM | | |
| 3. SEX MALE | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 18 1894 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Sanitation Eng. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Gaithersburg | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10015 Wedge Way 5300 WASHINGTON STREET | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM MENDELSON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline PAULINA BERG | | | | | ADDRESS Berg | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1926-1955 | | | 17. INFORMANT MILDRED MENDELSON 5300 WASHINGTON STREET | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) KIDNEY INFECTION DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC CARCINOMA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 10 days UNKNOWN | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 25 19 82 , to SEPTEMBER 14 19 82 , that (I) (we) lost saw the deceased alive on SEPTEMBER 14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE R. K. Ferguson 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. FERGUSON, LT, MC, USNR | | | | | | | | DEGREE LT, MC, USNR ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 15 Sept 82 | | | | | | |
| 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | | | | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS P.O. Box 7428 Sil. Spr., Md. | | | | | | | | 25. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 26. REGISTRAR'S SIGNATURE John J. Calkins | | | | | | |

BP

Wm. H. Miller

NOTES

1. The first thing I noticed when I stepped out of the plane was the cold. It was a sharp contrast to the warm air of the airport. I pulled my coat tighter around me and looked out at the snow-covered landscape. The trees were bare, their branches heavy with white. In the distance, a small town was visible, its houses and buildings also blanketed in snow. I took a deep breath, the cold air filling my lungs. It felt like a new beginning.

2. The second thing I noticed was the silence. It was a profound silence, the kind that comes after a storm. There were no cars on the roads, no people walking around. It was as if the world had stopped for a moment. I walked slowly, my boots crunching on the snow. The only sound was the soft rustle of my coat.

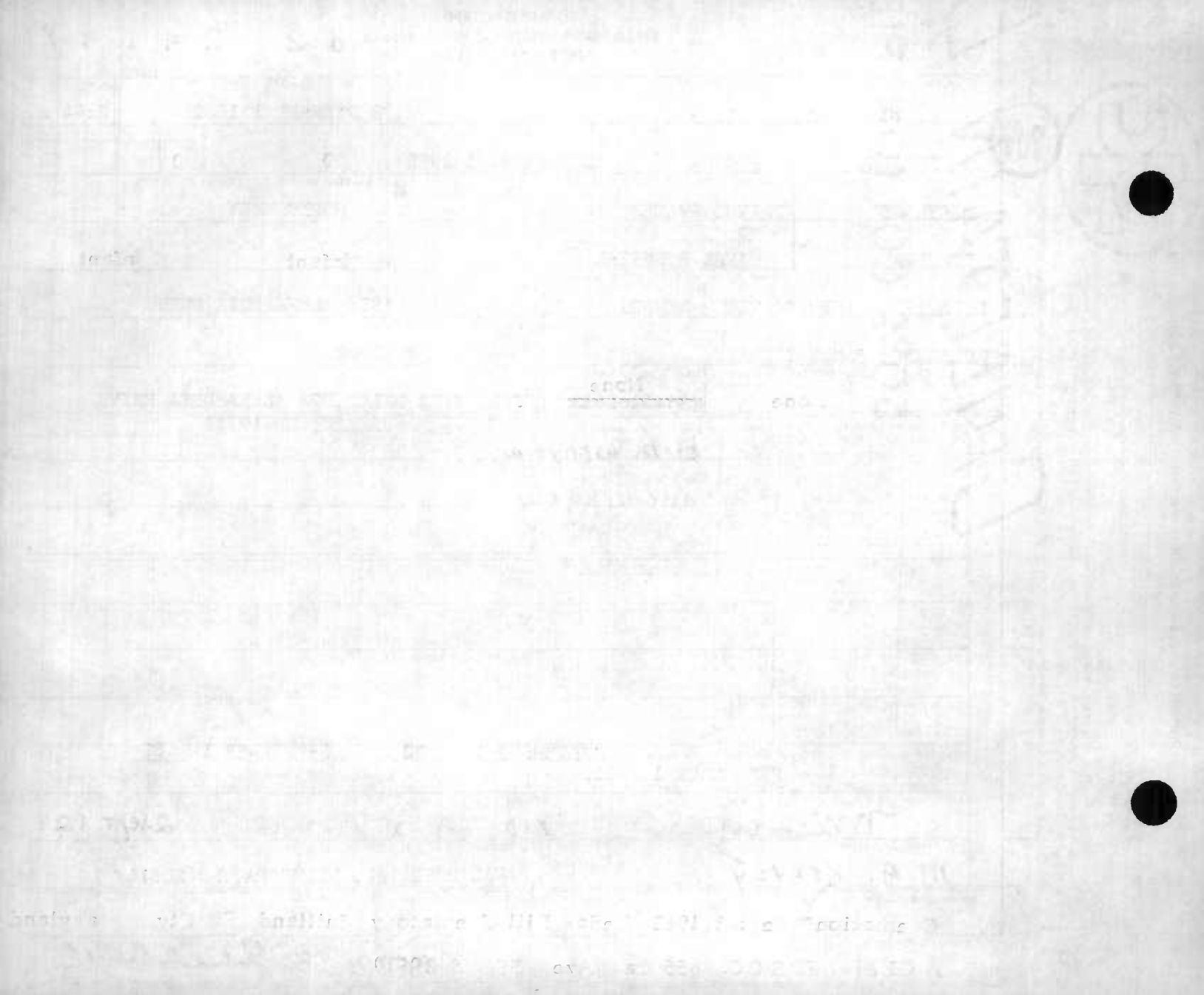
3. The third thing I noticed was the beauty. It was a beautiful sight, the way the snow had covered everything. The trees looked like giant white sculptures, and the houses in the distance were like little white villages. I felt a sense of peace and tranquility that I had never felt before. It was as if I had found a hidden world, a world where time stood still.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 4 7 REG. NO. | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICOLE ANICA MILES | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1 1982 | | 2b. HOUR 2:44 a.m. | |
| 3. SEX FEMALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 1 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. 0 MONTHS 0 DAYS | | IF UNDER 1 YEAR IF UNDER 24 HRS. 51 MIN. | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant | | 12b. KIND OF BUSINESS OR INDUSTRY Infant | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 13a. STREET ADDRESS 978 ALEXANDRIA DRIVE | | | | | |
| 13a. STATE DELAWARE | | 13b. CITY OR TOWN NEW CASTLE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 978 ALEXANDRIA DRIVE | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE JAMES STEWART | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANGELA INEZ MILES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS ANGELA INEZ MILES, 978 ALEXANDRIA DRIVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7400 IMMEDIATE CAUSE (a) birth asphyxia DUE TO, OR AS A CONSEQUENCE OF (b) anencephaly DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NEWARK, DE 19711 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 1, 19 82 , to SEPTEMBER 1, 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 1, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. A. KEAVEY | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 2 Sept 82. | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. KEAVEY | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Sept. 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Cty., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME W W CHAMBERS CO. 8655 Cal., Ave., SS, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR 29 SEP 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carroll | | | |

BP



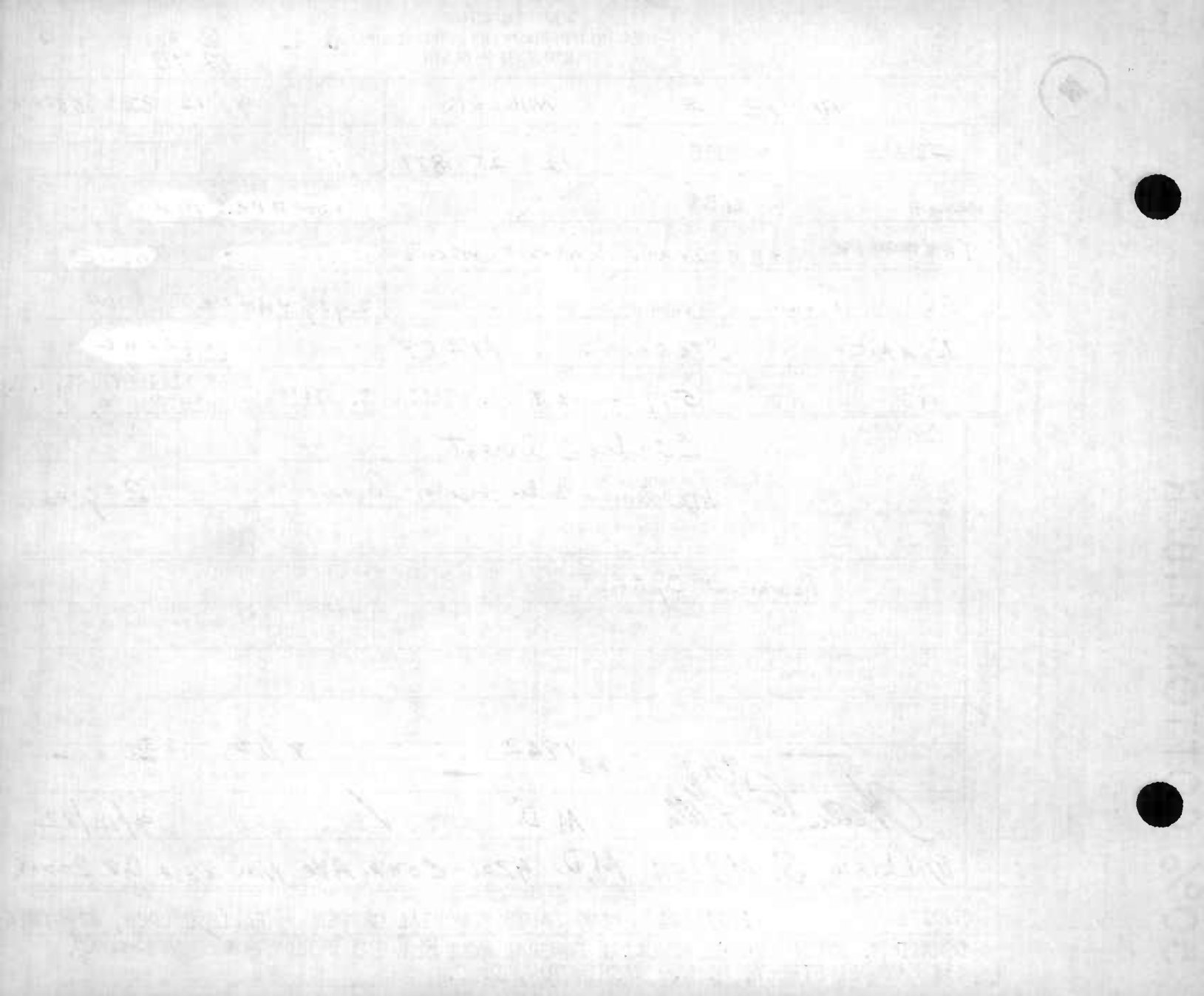
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 1 4 8 REG. NO. 1270 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ANNIE S | | MIDDLE MILLER | | 2a. DATE OF DEATH | | MONTH DAY YEAR 9 12 82 | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | | 7b. HOUR 1050 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 10. CITY OR TOWN OF DEATH TAKOMA PK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGORARDENS NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK, TO WHOM, AT WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC | | 13b. CITY OR TOWN none | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2939 VAW KESS ST NW | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ISAAC STERBING | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ZETLIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 577-68-2468 | | 17. INFORMANT ADDRESS DR. WILLIAM S. MILLER, 2908 ELLICOTT ST. N.W., WASHINGTON, D. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 4029 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent Cystitis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9/12</u> 19 <u>82</u> , to <u>9/12</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | 22b. SIGNATURE <u>William S. Miller</u> M.D. | | 22c. DATE SIGNED 9/12/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM S. MILLER M.D. | | 22e. ADDRESS 4201-CONN. AVE N.W. WASH. D.C. 20008 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | 23b. DATE 9/13/1982 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | SEP 15 1982 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 1 4 9 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Robert T. Miller | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 19 82 2b. HOUR 4 10 A.M. | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6 4 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nuclear Engr. | | 12b. KIND OF BUSINESS OR INDUSTRY EPA | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1112 Allison Drive 20851 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur C. Miller | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Osterblom | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT Lucy G. Miller same as 13e | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, hypoxemia DUE TO, OR AS A CONSEQUENCE OF (b) Brain positive bacteremia DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 36 hrs. 48 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cranial nerve palsy with depressed gag reflex 2° to TB meningitis. | | | | | | | | | |
| 19a. DATE OF OPERATION 1/5/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrostomy for feeding. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I (this hospital) attended the deceased from June 19 76 to September 19 82, that I (we) last saw the deceased alive on 9/16/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) did not view the body after death) | | | | | | | | | |
| 22b. SIGNATURE Thomas D. Garvey Jr. MD | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/19/82 |
| 22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT) Thomas D. Garvey Jr. | | | | | 22e. ADDRESS 11510 Old Georgetown Rd. Rockville | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Everett Massachusetts | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 5 0

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE W. MILLER, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-20-82 | | 2b. HOUR 7:20 PM |
| 3 SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 6 23 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH S.S. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | | 13b. COUNTY Mont. | 13c. CITY OR TOWN S.S. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST William D. Miller | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ellen Haller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None | | 16b. SOCIAL SECURITY NO. 214 03 8692 | | 17. INFORMANT ADDRESS Marcia E. Miller (Wife) Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY HEART DISEASE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 hours 6 days ? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: () | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 80 , to SEPT 20 , 19 82 , that (I) lost lost saw the deceased alive on 9-20 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED 9-21-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. PRISKIN, MD | | 22e. ADDRESS 809 VARS MILL RD, ROCKVILLE MD 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md. | | 23e. DATE REC'D. BY REGISTRAR SEP 23 1982 | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H. Ave. S.S. Md. | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 1 5 1 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Grace Miller | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 15, 1982 | | | 2b. HOUR 6:30p. M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 11, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Beltsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Zip Code - 20705 11384 Cherry Hill Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Barkley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Dermer | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | |
| | | 16b. SOCIAL SECURITY NO. 214-05-8205HB | | 17. INFORMANT ADDRESS Mrs. Bunny Hall Rockville, Md. 20850 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal adenocarcinoma, primary undetermined 1952 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pulmonary emphysema, cerebral metastases; partial intestinal obstruction | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (we) attended the deceased from August 15, 1982 to Sept. 15, 1982 , that (I) (we) last saw the deceased alive on Sept. 15, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Sidney J. Cohen</i> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D. | | | | 22e. ADDRESS 121 Congressional Lane - Rockville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) SEP 20 1982 John J. Connel | | | | | |

2. Macchia Rose E. H. Wyckville, Pa.

Partial 9-17-22 24. Lincoln County, Pennsylvania

x

No 214-7-20000 Pa. Hwy. Bldg. Rockville, Md. 20750
Robert Barker Tony
718 Cant Ave.
Detroit

Maryland T.O. Potomac x
11284 Cherry Hill Road
Baltimore 21206
214 Code - 20750

Pennsylvania U.S.A. x
White April 11, 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 5 2 | |
|---|--|--|--|--|--|
| FOR 1- STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Vera Williams Mitchell | | | | MONTH DAY YEAR September 16, 1982 | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 8. 1903 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2525 Briggs-Chaney Road | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REG. NURSE (RED) | | 12b. KIND OF BUSINESS OR INDUSTRY SAME | | 13a. STREET ADDRESS 2525 BRIGGS CHANEY RD | |
| 13b. COUNTY MONT. | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT WILLIAMS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA HOLDER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N | |
| 16b. SOCIAL SECURITY NO. 217-42-2310 | | 17. INFORMANT NANCY OROINA | | ADDRESS 2525 BRIGGS CHANEY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 CARCINOMA OF THE OVARY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) | | | |

BP



Revised

254 Carroll St,
N.W. Wash. D.C.

Takoma Park Home

Schnapp

1111 New Hampshire Ave, Bldg. 201, Wash.

Takoma

WILLIAMSON

Robert

Mont

Miss Mary

2542 Bridge-Chaney Road

Silver Spring 2525 Bridge-Chaney Road

2542 Bridge-Chaney Road

Female

Concession

Sept. 2, 1943

Controversy

Ver

Williams

Mitchell

September 16, 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 5 3 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| DANNEA JONNEE MOORE | | | | September 22, 1982 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Negro | | MONTH DAY YEAR | | 1 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BERMUDA | | BERMUDA | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda, Md | | The Clinical Center (NIH) | | NONE | | NONE | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Bermuda | | | | Hamilton Par. | | Lightbourne's Estate | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| DENNIS - MOORE | | | | JOHNETTE - PIQUES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | NONE | | Dennis Moore (father) same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| 2060 IMMEDIATE CAUSE (a) Respiratory Arrest | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 5 minutes | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | |
| (b) Pseudomonas Sepsis | | | | | | | |
| 4 days | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | |
| (c) Acute Monoblastic Leukemia, treated | | | | | | | |
| 20 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | |
| None | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from September 2, 1992, to September 22, 1982, that (X) (we) lost saw the deceased alive on September 22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Frank Balis | | | | M.D. | | Sept. 23, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| FRANK BALIS, MD | | | | National Institutes of Health 9000 Rockville Pike, Bethesda, Md 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| REMOVAL | | SEPT. 24, 1982 | | | | CITY OR TOWN COUNTY STATE | |
| | | | | | | HAMILTON, BERMUDA | |
| 24. FUNERAL DIRECTOR | | | | 24b. ADDRESS | | | |
| NAME | | | | ADDRESS | | | |
| CHAMBERS FUNERAL HOME | | | | SILVER SPRING, MD. | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|
| 8 2 2 4 1 5 4 CERTIFICATE OF DEATH | | | | | | | | | |
| FOR 1. STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET M. MORAN | | | | | | 2a. DATE OF DEATH MONTH 9 DAY 30 YEAR 82 2b. HOUR 8:25 P. M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 5 DAY XX YEAR XX | | 6. AGE (IN YEARS LAST BIRTHDAY) 46 | | IF UNDER 1 YEAR MONTHS 46 DAYS XX HOURS XX MIN. XX | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY PRI. GEORGE | | 13c. CITY OR TOWN BELTSVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11719 EMACK ROAD 20705 | |
| 14. FATHER'S NAME FIRST CHARLES MIDDLE W. LAST FERGUSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MARGUERITE MIDDLE A. LAST SULLIVAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 578-46-0606 | | 17. INFORMANT ADDRESS GERARD F. MORAN SAME AS 13 HUSBAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5722 IMMEDIATE CAUSE (a) HEPATO-RENAL INSUFFICIENCY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) HEPATITIS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HEPATO-ENCEPHALOPATHY | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 16 , 19 82 , to Sept 30 , 19 82 , that (I) (we) last saw the deceased alive on Sept 30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Bernard A. Fitzgerald M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9-30-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD | | | | 22e. ADDRESS 277 University Blvd E, Silver Spring MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD. | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

10-1-1947
Monsieur M. M. M.
F. F. F.
S. S. S.

10-1-1947
Monsieur M. M. M.
F. F. F.
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10-1-1947
Monsieur M. M. M.
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10-1-1947
Monsieur M. M. M.
F. F. F.
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10-1-1947
Monsieur M. M. M.
F. F. F.
S. S. S.

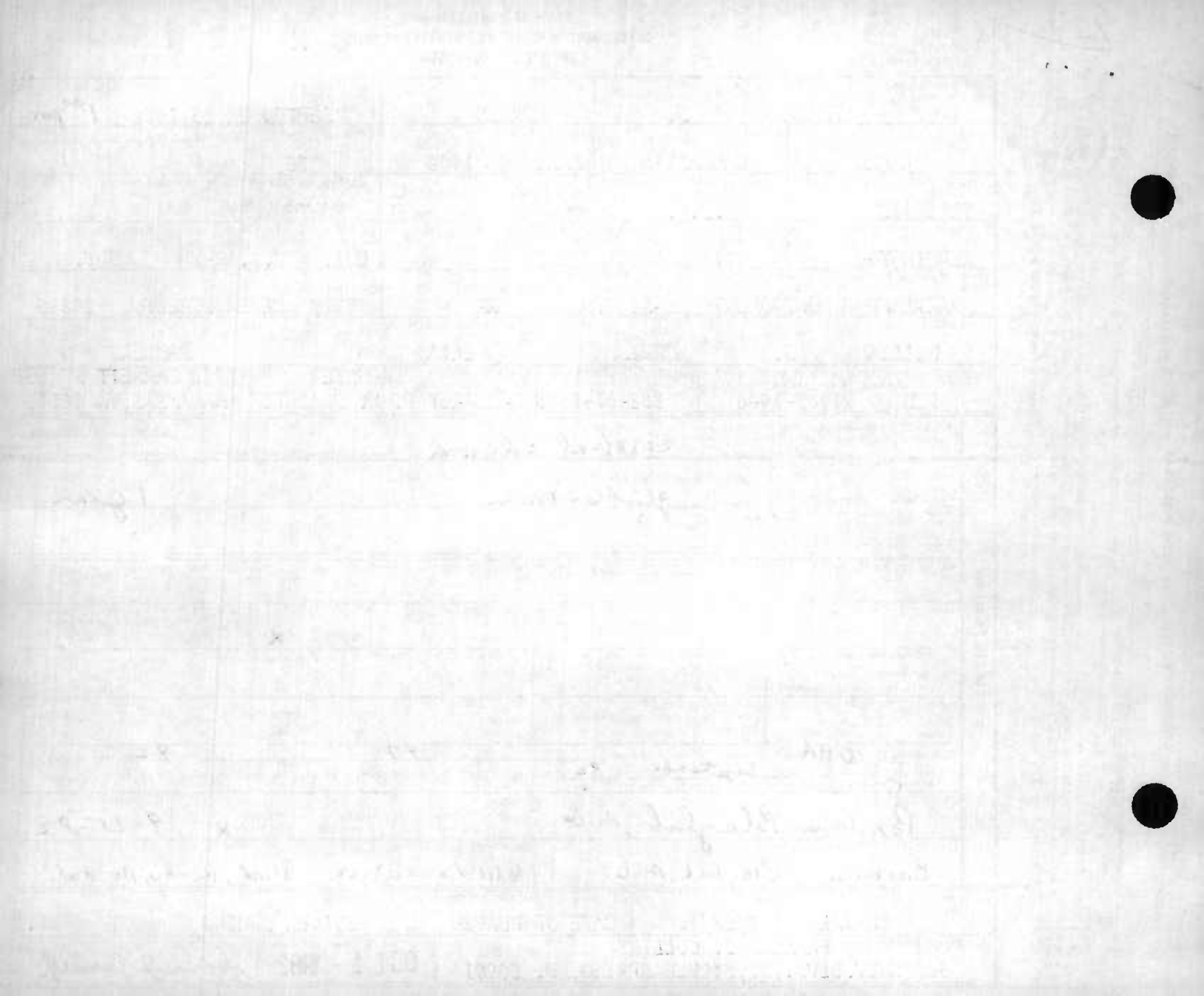
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 5 5 | |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK J. MORRIS | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 25, 1982 | | 2b. HOUR 1⁰⁰ PM |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH KENSINGTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9718 CULVER STREET | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COL. U.S. ARMY | 12b. KIND OF BUSINESS OR INDUSTRY GOVT. | |
| 13a. STATE MARYLAND | | | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN KENSINGTON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. MORRIS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA SAMUELS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 1943-1966 | 17. INFORMANT ADDRESS DAUGHTER 8808 BARNETT STREET MARGARET D. M. SHACHTER MANASSAS, VA 22110 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) cerebral edema DUE TO, OR AS A CONSEQUENCE OF (b) glibenclamide DUE TO, OR AS A CONSEQUENCE OF (c) 1 year | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (we) (he) (she) (it) (they) (the hospital) attended the deceased from September 19 82 to September 19 82 , that (I) (we) lost saw the deceased alive on September 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Barbara Blaylock, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9-25-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Blaylock, M.D. | | 22e. ADDRESS 6111 Executive Blvd, Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/28/82 | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE Joan J. Connel |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 4 1 5 6
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|-------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 9 | | 7 82 5 ³⁰ AM | |
| Charles W. Morton Sr. | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | |
| MALE | | WHITE | | MAY 14, 1906 | | 76 YRS. | | | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| WASHINGTON, D.C. | | U.S.A. | | | | MONTGOMERY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| GAITHERSBURG | | 880 WESTSIDE DRIVE | | FURNITURE SERVICE MAN | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | MONTGOMERY | | GAITHERSBURG | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 880 WESTSIDE DRIVE | | | |
| 4. FATHER'S NAME | | 5. MOTHER'S MAIDEN NAME | | 6. SON | | 7. ADDRESS | | | | | |
| DAVID P. MORTON | | ROSE E. SHERZEE | | | | 1122 WEST NOLCREST RD | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 578-05-2121 | | CHARLES W. MORTON, JR. | | SILVER SPRING, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1850 | | | | Metastatic Prostatic Carcinoma | | | | 2 mo. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (b) Arenal insufficiency 20 | | | | | | | |
| | | | | (c) obstructive uropathy | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 7/6 19 82, that (I) (we) last saw the deceased alive on 8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| | | Francis J. Collins, MD | | | | 9/8/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| Francis J. Collins | | 10301 Georgia Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| BURIAL | | 9/9/82 | | FT. LINCOLN | | BRENTWOOD | | PRI GEO | | MD. | |
| 24. FUNERAL DIRECTOR NAME | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| FRANCIS J. COLLINS | | SEP 10 1982 | | John J. Carver | | | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

1 SEP 5 0 10 40 AM '54
Charles W. Foster
M. F. Foster

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 2 4 1 5 7 | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Maurice P Murphy</i> | | | | 2a DATE OF DEATH MONTH DAY YEAR <i>9-19-82</i> | | 2b HOUR <i>11:30 P</i> | |
| 1 SEX <i>Male</i> | | 4 RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>March 17, 1931</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i> YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) <i>Washington, D.C.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | |
| 10 CITY OR TOWN OF DEATH <i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Computer Sales</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Computers</i> | |
| 13a STATE <i>Maryland</i> | | | | 13b COUNTY <i>Montgomery</i> | | 13c CITY OR TOWN <i>Rockville</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas D. Murphy</i> | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hannah Collins</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i> | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Korean</i> | | 17 INFORMANT ADDRESS <i>Alice V. Murphy see # 13 zip 20850</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction 1/2 hour</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart dis 10 years</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>instant</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> 19 <i>72</i> to <i>5/20</i> 19 <i>82</i> that (I) (we) lost saw the deceased alive on <i>5/20</i> 19 <i>82</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Morton W. Shapiro</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/20/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Morton W. Shapiro</i> | | | | 22e. ADDRESS <i>5225 Rock Hill Rd Beltsville</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Sep. 22, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring, Maryland</i> | |
| 24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> | | | | 25 DATE RECEIVED BY REGISTRAR <i>SEP 22 1982</i> | | 26 REGISTRAR'S SIGNATURE <i>John J. Smith</i> | |
| P.A. Rockville, Maryland | | | | | | | |

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|--|------------------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 1 5 8 | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | |
| (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | |
| John Carlton Neel | | | | | 9-10-82 8:35 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | BLACK | | Aug. 14, 1903 | | 79 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PA. | | U.S.A. | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST SIGNIFICANT) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban Hospital | | | | United Disposal | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Montg. | | Rockville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 617 Douglas Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| JOHN Neel | | | | Martha White | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 216-12-0349 | | Jeanette Neel (wife) same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | Cardio-respiratory arrest |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 15' |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) | | | | | | | | | Anoxemia, dehydration & anemia |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 3 mos |
| (c) | | | | | | | | | Carcinoma of bladder & fibrom |
| | | | | | | | | | 1 yr. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21/82 to 9/10/82 that (I) (we) last saw the deceased alive on 9/9/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| Stephen Jones | | | | | | | | 9/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Stephen Jones, M.D. | | | | | 809 Veirs Mill Rd, Rockville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 9-14-82 | | Lincoln Park Cem. | | Rockville, Montg Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| George R. Snowden | | | | | 446 N. Wash. Rockville, Md. | | SEP 16 1982 | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

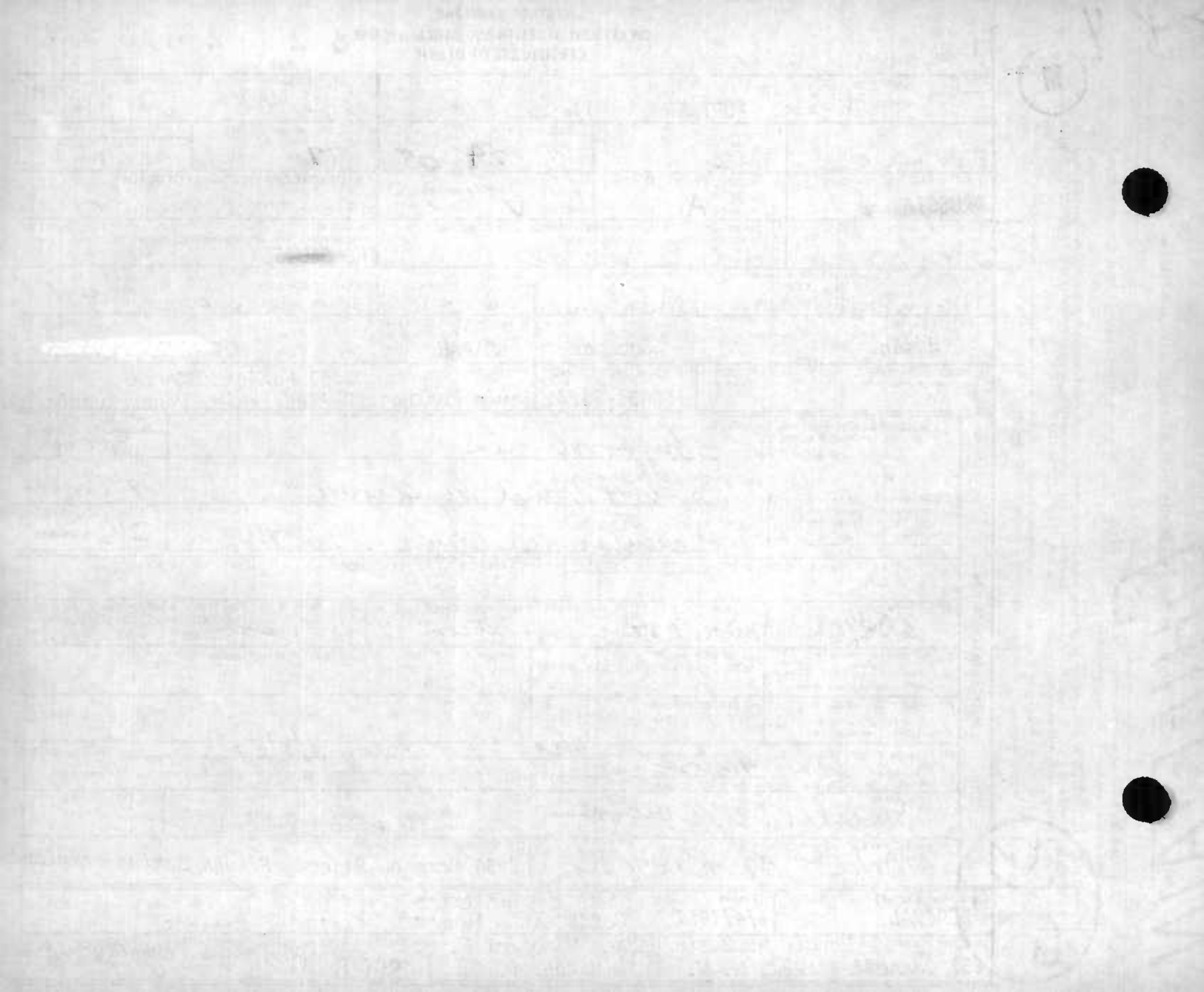
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 4 1 5 9 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida PORTNER Nepp | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-4-82 | | | 2b. HOUR AM PM 1:30 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 24 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 77 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY — | |
| 13a. STATE Maryland | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 15310 Beaverbrook #1B | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hyman Goodman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH NOT ASCERTAINABLE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | |
| 16b. SOCIAL SECURITY NO. 150-38-8824 | | 17. INFORMANT ADDRESS Irvin Portner 7251 Hanford Street Philadelphia, Pennsylvania | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypovolemia 5570 DUE TO, OR AS A CONSEQUENCE OF (b) "shock bowel syndrome" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) vascular mesenteric infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 1/2 mos 2 1/2 mos | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 6/28/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED mesent vasc infarction | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/28/82 , 19 82 , to 9/3/82 , 19 82 , that (I) (we) lost saw the deceased alive on 9/3/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stanley M Kirson | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY M KIRSON | | | | 22e. ADDRESS 8830 Cameron Street, Silver Spring, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | | 23b. DATE 9/4/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Goldstein's Funeral | | 23d. LOCATION CITY OR TOWN COUNTY STATE 6410 No. Broad St. Philadelphia, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR NAME Donald M. Stein | | | | 24b. ADDRESS Hefre Memorial F. H. 232 Carroll Street, N. W. Washington, D. C. | | 24c. DATE RECEIVED BY REGISTRAR (DATE OF REGISTRAR'S SIGNATURE) SEP 8 1982 | | | |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 1 6 0 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE A. NINAS, JR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-21-82 | | | | 2b. HOUR 1:55 PM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 3, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) (UNKNOWN) | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYLVAN MANOR HEALTH CARE CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PATENT ATTN. | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T. | | | |
| 13a. STATE MD. | | 13b. COUNTY MONT. | | 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5009 ALLAN RD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN) | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-58-5938 | | 17. INFORMANT ADDRESS J. LAWRENCE KENT 6241 EXECUTIVE BLD. MD. ROCKVILLE, | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3109 manacian DUE TO, OR AS A CONSEQUENCE OF (b) Sever Chronic Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) decubiti | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a recurrent epistaxis | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/21/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1973 19____, to 9/21/82 19____, that (I) (we) last saw the deceased alive on 8/18/82 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jeremy V. Cooke | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/21/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke | | | | 22e. ADDRESS 10400 Conn Ave Kensington | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD. | | | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | ADDRESS SILVER SPRING, MD. | | | | 25. REGISTRAR'S SIGNATURE SEP 24 1982 | | | |

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GEORGE

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(unclassified)

(unclassified)

SEP-22-1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 6 1 | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Santina S. Niosi | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 7 82 | | 2b. HOUR 5:45 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 17 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19460 Olney Mill Road, | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Cleaner | 12b. KIND OF BUSINESS OR INDUSTRY Wash. Terminal Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Olney | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dominico Smirolodo | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-05-1743 | | 17. INFORMANT ADDRESS Fanny Roccia-daughter-(same as 13e) | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4110 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) 4110 Atrial Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) 4110 Coronary Insufficiency | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years 7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from Aug 32 , 19 75 , to Sept. 7 , 19 82 , that (1) (we) last saw the deceased alive Aug 32 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) visit the body after death. | | | | | |
| 22b. SIGNATURE Lewis Kellert, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, M.D. | | 22e. ADDRESS 18111 Prince Phillip Dr. Olney, Md. 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPEC Burial | | 23b. DATE 9-10-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md. | | 23e. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | ADDRESS 11800 N.H. Ave., S.S. Md. | | 24b. REGISTRAR'S SIGNATURE John J. Carney | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 6 2 | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Albert N Nokes | | | | MONTH DAY YEAR 09 13 82 | | | | 1410 M | | | |
| 3. SEX M | | 4. RACE N Y | | 5. DATE OF BIRTH MONTH DAY YEAR 01 02 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 708 Douglas Ave | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN NOKES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Woodson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Malinda Nokes (wife) same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiomyopathy</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2) | | | | | |
| 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles W. Kershner | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/13/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARESH, Charles W | | | | 22e. ADDRESS Graftonburg MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | 24b. ADDRESS 246 N. Wash. St. Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1982 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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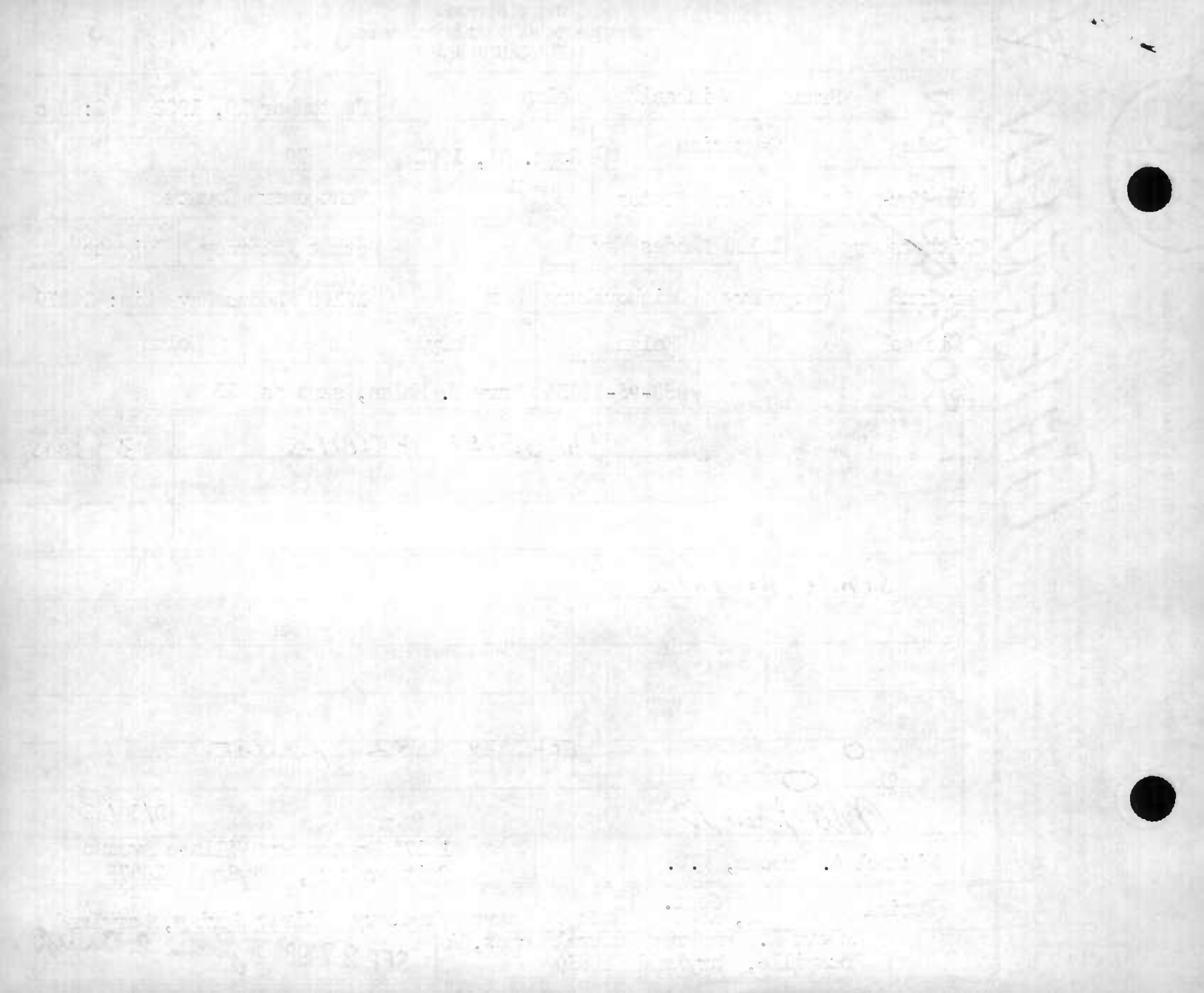
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8 2 2 4 1 6 3 | |
| 1. DECEASED NAME (TYPE OR PRINT) Frank Michael Nolan | | 2a. DATE OF DEATH MONTH DAY YEAR September 19, 1982 | |
| 3. SEX Male | | 2b. HOUR 2:28 a.m. | |
| 4. RACE Caucasian | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1902 | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? United States | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Patent Attorney | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 12b. KIND OF BUSINESS OR INDUSTRY Private | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19109 Rhodes Way | | 13a. STREET ADDRESS 19109 Rhodes Way | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Gaithersburg | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. ZIP CODE Zip: 20879 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Nolan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Nolan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 058-05-8863A | |
| 17. INFORMANT ADDRESS Mary E. Nolan, same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2500 DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>Senile dementia</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 24, 1982</u> to <u>present</u> , 19____, that (1) (we) last saw the deceased alive on <u>19____</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Michael A. Greene</u> | | 22c. DATE SIGNED 9/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Greene, M.D. | | 22e. ADDRESS 19271 Montgomery Village Avenue Gaithersburg, Maryland 20879 | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Sept. 22, 1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | |

25b. REGISTRAR'S SIGNATURE
John J. Connelley



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. 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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|---|----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 2 4 1 6 4 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENGT KONSTANTIN NORDENSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2 1982 | | 2b. HOUR 8:55 PM | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 14 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SWEDEN | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY | |
| 13a. STATE FLORIDA | | 13b. COUNTY SARASOTA | | 13c. CITY OR TOWN SARASOTA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4171 ROBERTS POINT CIRCLE (33581) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST KNUT KONSTANTIN NORDENSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GYLING | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1936-1959 | | 17. INFORMANT ADDRESS BENGT KARL NORDENSON, 6702 MELVILLE PLACE CHEVY CHASE, MD 20015 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis and Fungemia DUE TO, OR AS A CONSEQUENCE OF (c) Prostatic CA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 0389 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Respiratory failure, renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 16 1982 to SEPTEMBER 2 1982 , that (I) (we) lost saw the deceased alive on SEPTEMBER 2 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Matthew Barton Lt MC | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 9/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MATTHEW BARTON, LT, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Auburn, New York | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |



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RECEIVED

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10/10/10

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SEP 14 1910

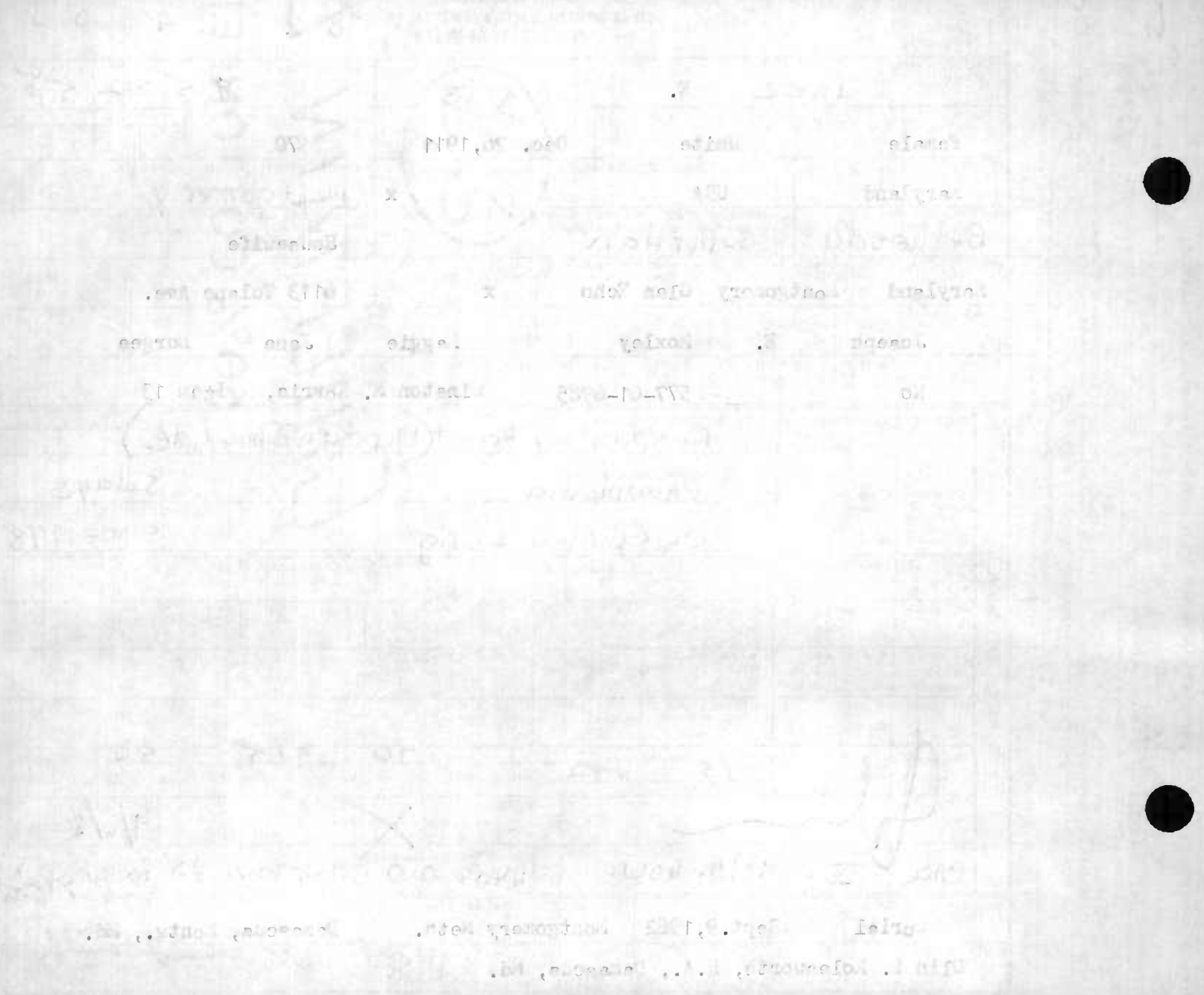
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 6 5 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Inez E. Norris | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 5 82 2b. HOUR 5 P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Glen Echo | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Moxley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Jane Burgee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-01-6985 | | 17. INFORMANT ADDRESS Winston M. Norris, Item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest (Duration Immediate) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) Carcinoma Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days Since 1978 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 9/5 , 19 82 , that (I) (we) lost view the deceased alive on 7/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN | | 22c. DATE SIGNED 9/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL I. MARGOLIS | | | | 22e. ADDRESS 11404 OLD GEORGETOWN RD, ROCKVILLE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montg., Md. | |
| 24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | |

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 1. FOR Items 19a&b film 578
 STATE REGISTRAR 4-27-83 cn

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 2 2 4 1 6 6

REG. NO.

| | | | | | | |
|--|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS ROYAL NUNNALLY | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 27, 1982 | | 2b. HOUR 5:10 p.m. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 12, 1923 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver | | |
| 13a. STATE North Carolina | | 13b. COUNTY Lenoir | | 13c. CITY OR TOWN Kinston | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS p.o. Box #3372 (28501) | | 13f. STREET ADDRESS | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard C. Nunnally | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Fields | | 16. ADDRESS Rt. 3, Box 480 Tracy Nunnally, dgtr Montross, Va. 22520 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-18-9863 | | 17. INFORMANT Tracy Nunnally, dgtr | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS 20 to mediastinitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 month.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 1 month. | |
| PART 2. OTHER MEDICAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>SLP Mitral valve replacement; SLP coronary artery by pass graft.</u> | | | | | | |
| 19a. DATE OF OPERATION 6-7-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease Mitral stenosis | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I, (this hospital) attended the deceased from <u>May 30</u> , 19 <u>82</u> , to <u>September 27</u> , 19 <u>82</u> , that (s) (we) lost saw the deceased alive on <u>September 27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (do not) view the body after death. | | | | |
| 22b. SIGNATURE <u>Robert R. Artwohl</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/28/82</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert R. ARTWOHL</u> | | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, THE CLINICAL CENTER, BETHESDA, MD 20205 | | 22f. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Pinelawn Mem. Park | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Kinston North Carolina | | 24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | |
| 25a. DATE REC'D. BY REGISTRAR OCT 5 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | | |

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 31 is marked as any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

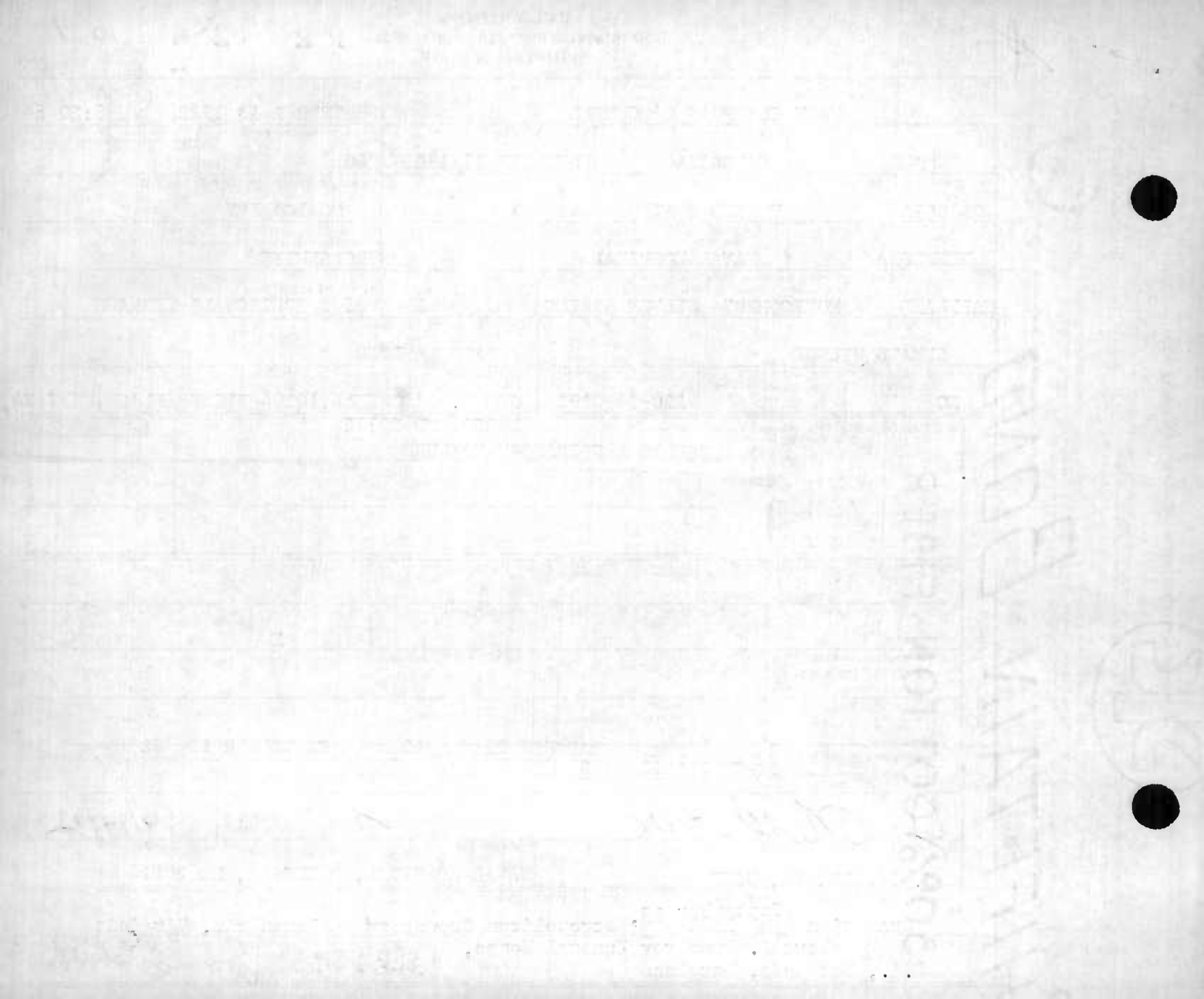
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 6 7

REG. NO.

| | | | | | | |
|---|--|--|---|---|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY CLEOPHAS O'DONNELL | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13 1982 | | 2b. HOUR 8:20 a.m. | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 11 1901 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) 80 | | 7. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA | | 9b. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY | | 9c. MD. | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD WILSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PARK LAMBETH | | 16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 17b. SOCIAL SECURITY NO. 220-34-0192 | | 17c. INFORMANT JON P. O'DONNELL, 10204 PRINCE PLACE, APT T4, | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7991 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 22 , 19 82 , to SEPTEMBER 13 , 19 82 , that (I) (we) lost saw the deceased alive on SEPTEMBER 13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE J. O'NEIL, LT, USNR | | DEGREE | | 22c. DATE SIGNED 9/14/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. O'NEIL, LT, USNR | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE September 15 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | 23e. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 23f. REGISTRAR'S SIGNATURE John J. Connel | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A., Bethesda, Maryland | | | | | | |

BP

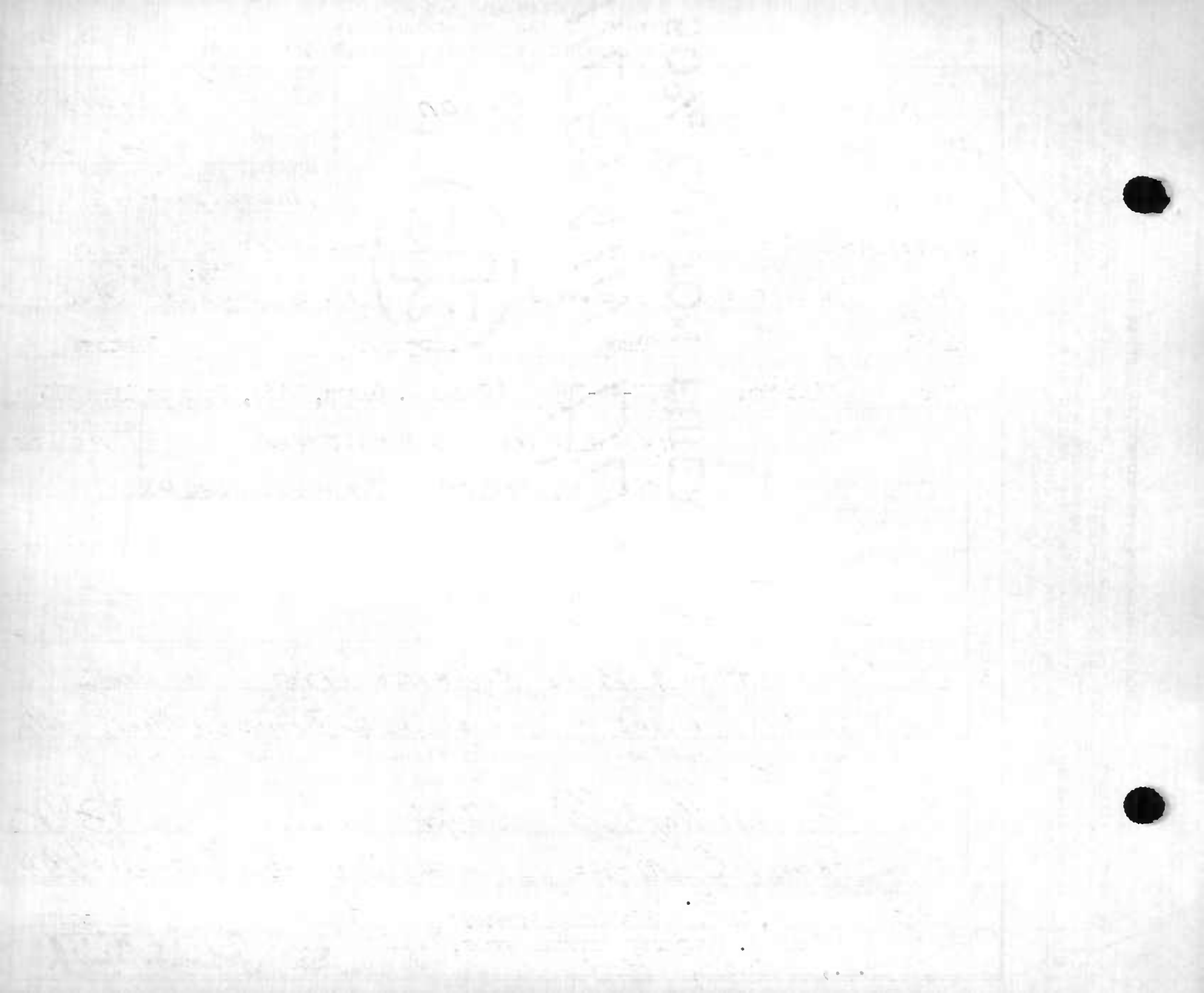


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24168 | |
|--|------------------------|---|---|---|--------------------------------|--|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) KENNETH J. OLSON | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 24 1982 | | 2b. HOUR 5 25 PM | | | |
| 3. SEX M | 4. RACE CAUC | 5. DATE OF BIRTH MONTH DAY YEAR 7 23 40 | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 24 1982 | | 2d. HOUR 5 30 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINN | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRANSLATOR | | 12b. KIND OF BUSINESS OR INDUSTRY GOVT. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE MD | | 13b. CITY OR TOWN MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13e. STREET ADDRESS 9912 DICKENS AVE | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Olson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Flattum | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 392-40-3989 | | 17. INFORMANT ADDRESS Susan M. Olson, Wife, Same as item #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 4100 (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 4 45 P.M. 9 24 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AFTER JOGGING | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION STREET 9912 DICKENS AVE | | CITY OR TOWN BETHESDA | | COUNTY MONTGOMERY | | | |
| STATE MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Francis C. Mayle</i> | | | | TITLE (SPECIFY) Dept | | MEDICAL EXAMINER | | DATE SIGNED 9/30/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE | | | | ADDRESS 8200 WISCONSIN AVE BETHESDA MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery | | 23d. LOCATION CITY OR TOWN Whelan | | COUNTY Minneapolis | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Bumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 5 - 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i> | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HERMAN C OWENS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 82 | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 23 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 2b. HOUR 11:55 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy CROSS HOSPITAL SS | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed | | 12b. KIND OF BUSINESS OR INDUSTRY Store | |
| 13a. STATE D.C. | | 13b. COUNTY NW | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3636 13th St. NW | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Owens | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Carter | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT Fannie Mae Owens | | ADDRESS 3636 13th St. Wash.D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-11 19 82 , to 9-17 19 82 , that (I) (we) last saw the deceased alive on 9-16 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Norman S. Koval DEGREE MD | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman S. Koval MD | | | | | 22e. ADDRESS 8750 Georgia Ave Silver Spring MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 21 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Maryland | | | |
| 24. FUNERAL DIRECTOR John 7606 ADDRESS 7400 Georgia Ave Washington D.C. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 REGISTRAR'S SIGNATURE John J. Canfield | | | | |

1978-1979 1980-1981 1982-1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 7 0 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julius - Panitz | | | | 2a DATE OF DEATH MONTH DAY YEAR September 20, 1982 | | 2b HOUR 6:50 a.m. | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR January 10, 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 87 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10 CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | 12b KIND OF BUSINESS OR INDUSTRY Plumbing | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a STATE Maryland | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Bethesda | | 13e STREET ADDRESS 8101 Hamilton Spring Rd. (20817) | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Abraham - Panitz | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel - (Unknown) | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17 INFORMANT ADDRESS Sol Panitz (Son) Same as # 13. | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebromotor disease DUE TO, OR AS A CONSEQUENCE OF (c) Diverse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS 2 yrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from May 1982 to Sept 20, 1982 , that (I) (we) last saw the deceased alive on Sept 20, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Richard H. Pollen | | | | DEGREE MD | | 22c DATE SIGNED Sept/20/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard H. Pollen, M.D. | | | | 22e ADDRESS 10400 Conn. Ave. Kensington, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE Sept/21/82 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Co., Maryland | |
| 24 FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | ADDRESS Silver Spring, Md. | | 25a DATE RECEIVED BY REGISTRAR SEP 24 1982 | |

10:00 AM - 10:15 AM

10:15 AM - 10:30 AM

10:30 AM - 10:45 AM

10:45 AM - 11:00 AM

11:00 AM - 11:15 AM

11:15 AM - 11:30 AM

11:30 AM - 11:45 AM

11:45 AM - 12:00 PM

12:00 PM - 12:15 PM

12:15 PM

12:30 PM - 12:45 PM

12:45 PM - 1:00 PM

1:00 PM - 1:15 PM

1:15 PM - 1:30 PM

1:30 PM - 1:45 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your other death records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 7 1
REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) NELLIE | | | FIRST MIDDLE LAST Romeo PAPPALARDO | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 2 1982 | | | 2b. HOUR 1108 P.M. | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1922 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY pwn home | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Potomac | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmelina | | | 13e. STREET ADDRESS 8911 Persimmon Tree Road | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- | | | 17. INFORMANT Anthony V. Pappalardo-husband-(same as 13e) | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from August 28, 1982 , to September 2, 1982 , that (I) (we) last saw the deceased alive on September 2, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Barry Hecht | | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED September 3, 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Hecht, MD | | | | | | 22e. ADDRESS 3929 PENNA DRIVE WHEATON MD 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9-7-1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md. | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | |

BP

Environ

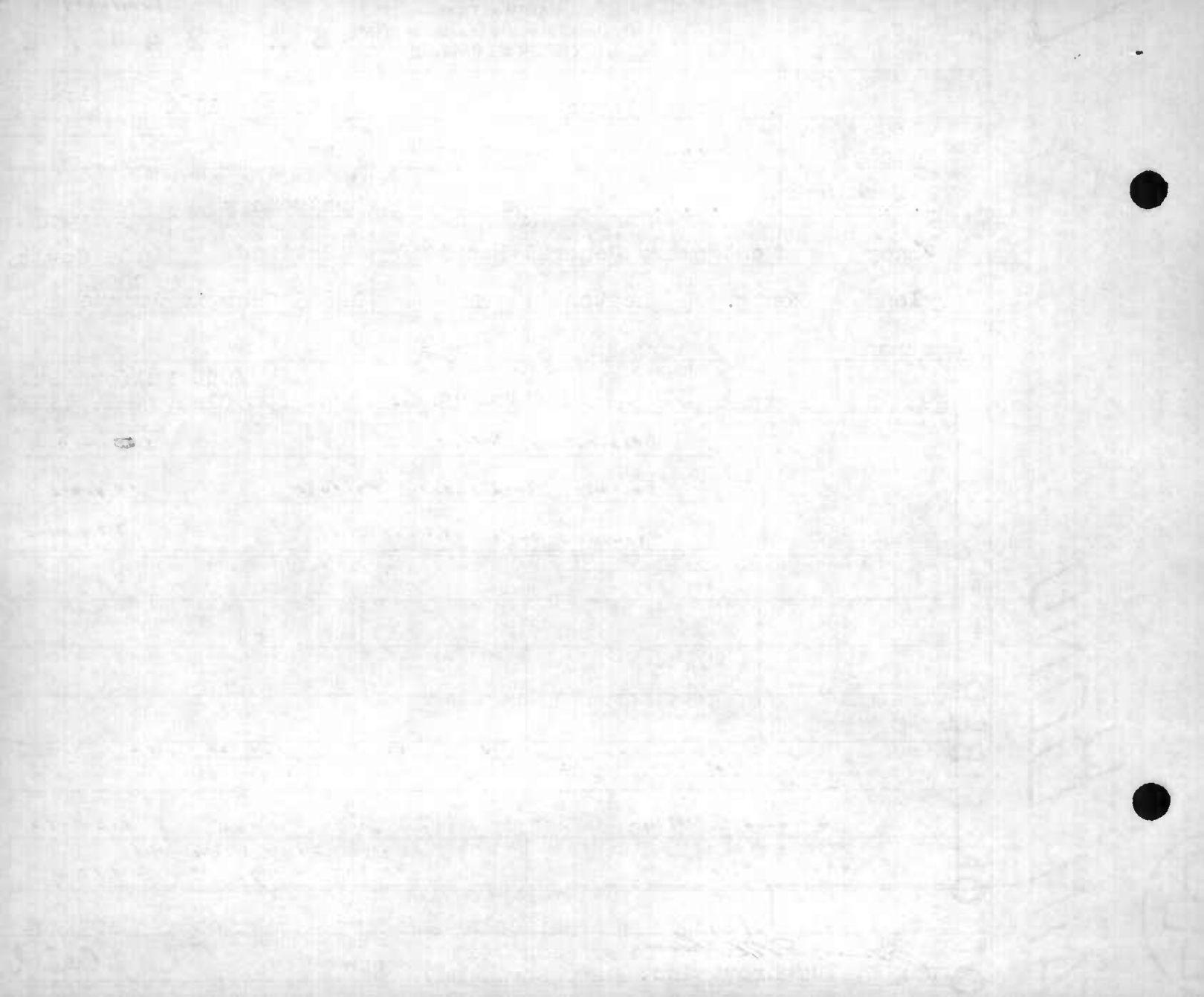
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 4 1 7 2
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) K. May Payne | | | 2a DATE OF DEATH MONTH DAY YEAR Sept. 20, 1982 | | | 2b HOUR M 1:40PM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 05 07 05 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. Washington | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 13a. STATE Maryland | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Wheaton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 20906 12633 Georgia Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Bertran A. Herriman | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lyda Howes | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17 INFORMANT ADDRESS 4000 Fulford St. Robert L. Payne-Son Olney, Md. 20832 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>7561</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic Respiratory Failure</u> (c) <u>Kyphoscoliosis (Thoracic)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 years</u> <u>77 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Sept. 13</u> , 19 <u>82</u> , to <u>Sept. 20</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept. 19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Frank J. Moyo</u> DEGREE <u>M.D.</u> | | | | | | 22c. DATE SIGNED <u>9-20-82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank J. Moyo</u> | | | | | | 22e. ADDRESS <u>1622a Frederick Rd.</u> <u>Gaithersburg, Md 20877</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>9/23/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Maryland</u> | | |
| 24 FUNERAL DIRECTOR NAME <u>Warner E. Pumphrey, Inc.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 27 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

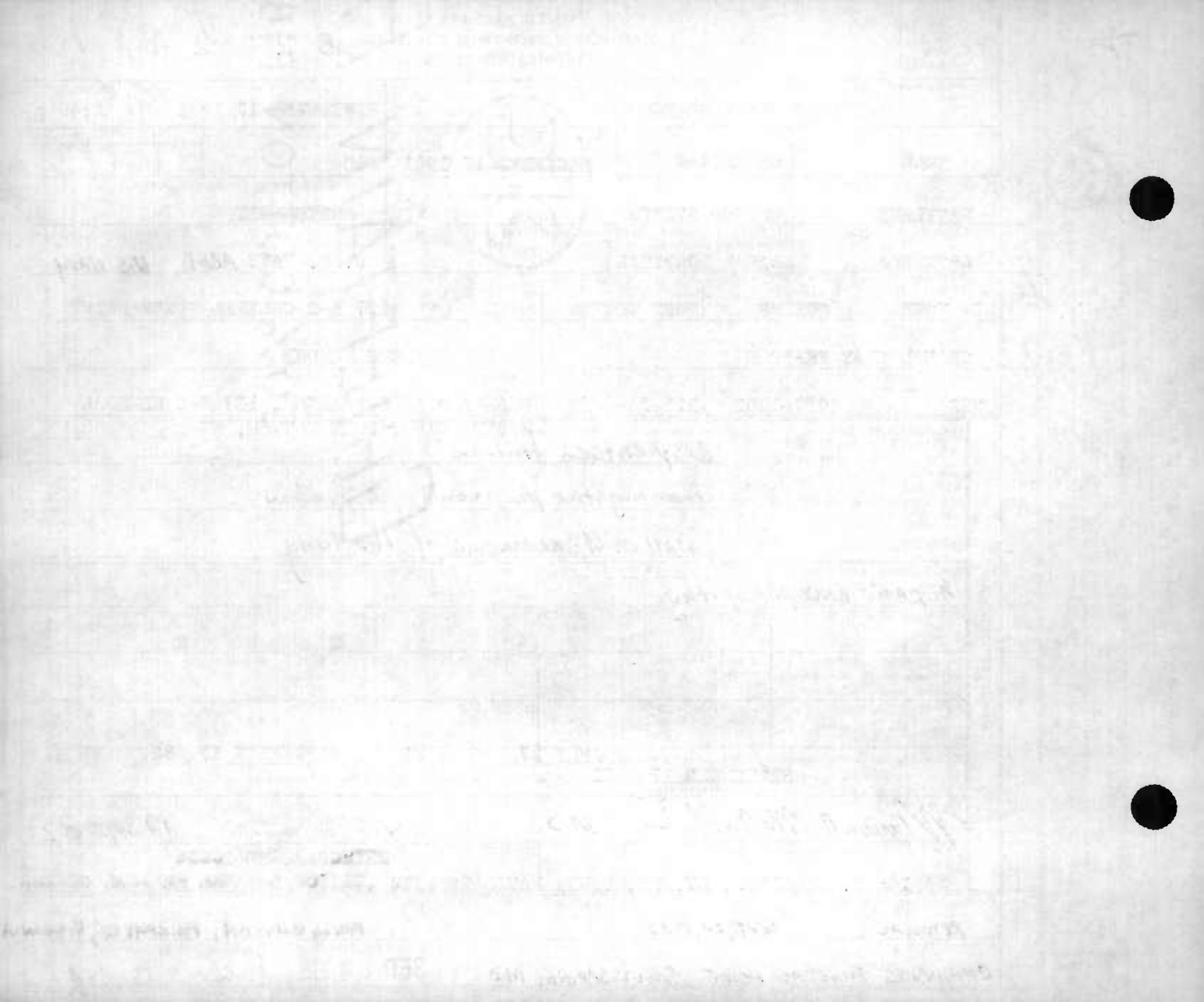


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 2 4 1 7 3 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GRAHAM HENRY PEARSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 17 1982 | | 2b. HOUR 2:40 PM | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 10 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY) 40 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. NAVY ABHI | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NEW YORK | | | | | 13b. COUNTY QUEENS | | 13c. CITY OR TOWN FORT TOTTEN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GRAHAM CLAY PEARSON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FRANCES MCKUEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1959-1982 | | 17. INFORMANT ADDRESS DEANNA JEANNE PEARSON, 137 B-2 GENERAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>gram negative pneumonia, Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>small cell carcinoma of the lung</i> BERRY DRIVE, FORT TOTTEN, NY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>hepatic encephalopathy</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 27</u> , 19 <u>82</u> , to <u>SEPTEMBER 17</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>SEPTEMBER 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Marion R. McMILLAN</i> M.D. | | | | | DEGREE M.D. | | | 22c. DATE SIGNED 17 Sept. 82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARION R. McMILLAN, LT, MC, USNR | | | | | 22e. ADDRESS BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE SEPT. 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, FAIRFAX CO., VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | | ADDRESS SILVER SPRING, MD | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | |
| | | | | | REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|--|------------------------------------|--|---|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8 2 2 4 1 7 4 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA M. Peck | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 9 29 82 10 ²⁰ AM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Wash. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Morris Cohen | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Shapiro | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS Marcia Weinberg; 9273 Bailey Lane; Fairfax, Va. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> 4210 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pneumonia</u> (c) <u>Possible subacute Bact. endocarditis.</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/57</u> 19 <u>79</u> to <u>9/29/82</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>9/29/82</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE H. D. Khramy | | 22c. DATE SIGNED 9/29/82 | | | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERV. D. KHAMNEY | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY D.C. LODGE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C. | | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | | | | | 25. DATE REC'D. BY REGISTRAR OCT 1 1982 | | | | | |

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Item #6 Film G572 10/22/82 rc

STATE OF MARYLAND

FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 7 5

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael - JOHN Pellegrino | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-27-82 | | | 2b. HOUR 10:53^M | | | | |
| 3 SEX Male | | 4 RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 4-24-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 82 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CEMENT WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST VINCENT PELLEGRINO | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NICOLINA DeSANTO | | | 13e. STREET ADDRESS 14213 GRAND PRE ROAD 20906 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 206-05-9282 | | 17. INFORMANT VIRGINIA PELLEGRINO | | | | ADDRESS SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY 5770 IMMEDIATE CAUSE (a) multiple abdominal Abscesses DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatitis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 mos | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease, Prostatic Hypertrophy | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/3/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatic Hypertrophy | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 3) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (ST HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from July 1976 to 9/27/82 that (i) (we) last saw the deceased alive on 9/26/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE R. T. Benack MD | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/27/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. Benack MD | | | | 22e. ADDRESS 4115 Edie Dr. Wheaton, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 Univ. Blvd., W., Silver Spring, Md. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Michael - The Fellowship

11/20/2010 4:24-5:00

11/24

St. George's Hospital

St. George's Hospital
New York, NY

St. George's Hospital
New York, NY

St. George's Hospital
New York, NY

St. George's Hospital
New York, NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Entry 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 4 1 7 6 REG. NO. | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (PEREZ) Alfonso PEREZ | | | | 2a. DATE OF DEATH MONTH DAY YEAR 8-27-82 | | 2b. HOUR 130 P.M. | |
| 3. SEX M | | 4. RACE Hispanic | | 5. DATE OF BIRTH MONTH DAY YEAR 8-2-54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA | | 7b. CITIZEN OF WHAT COUNTRY? Cuba | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Sil. Spr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 430 45 8025 | | 17. INFORMANT ADDRESS Leonor Cortinas (same as #13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4300 IMMEDIATE CAUSE (a) Brain death 2° to extensive bilateral DUE TO, OR AS A CONSEQUENCE OF (b) subarachnoid hemorrhage, causing DUE TO, OR AS A CONSEQUENCE OF neurogenic pulmonary edema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 3 1/2 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Life support removed with consent of wife on 8/27/82 | | | | | | | |
| 19a. DATE OF OPERATION N.A. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8-23-1982 to 8-27-1982 , that (I) (we) lost saw the deceased alive on 8-25-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Frederic H. Brennwald M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8.27.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. BRENNWALD | | | | 22e. ADDRESS 821 University Blvd E. Silver Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 8-31-82 | | 23c. NAME OF CHURCH OR CREMATORY Metropolitan | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va. | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey Inc. | | | | 24b. ADDRESS 8434 Ga. Ave. Sil. Spr. Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Carick | | | | | | | |



(P. 100)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 1 7 7 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) IRBNE Nannie PERSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 11 82 | | 2b. HOUR 2⁰⁰ M | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD. | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Dept. of Agriculture | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Germantown | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Crawford Person Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hurley Ida Tillotson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 246 12 9440 | | 17. INFORMANT Sister Maggie Person ADDRESS 601 Coggeshall Street Oxford, North Carolina | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Anoxia, Coma DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrest 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 wks. 2 wks. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cardiac Arrhythmia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 81 , to 9-11 , 19 82 , that (II) (we) lost saw the deceased alive on 9-10 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did/did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John A. Galotto, M.D. | | | | 22c. DATE SIGNED 9-11-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galotto, M.D. | |
| 22e. ADDRESS 5225 Pooks Hill Rd Bethesda Maryland 20814 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Oxford North Carolina | |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Sybil C. Pfleger</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 29 82</i> | | 2b. HOUR <i>1:45 PM</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>Caucasian</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>September 4, 1887</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>95</i> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maine</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. |
| 10. CITY OR TOWN OF DEATH <i>Rockville</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Asst. to Curator</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>Museum</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Bethesda</i> | 13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Genevieve Hamilton</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>008-24-6656A</i> | | 17. INFORMANT ADDRESS <i>Janet H. Pfleger (same as 13e)</i> |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4413 Cardiac Arrest</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> |
| IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> | | <i>12 hrs</i> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured Abdominal Aneurysm</i> | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | |

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION <i>9-28-82</i> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ruptured Aneurysm</i> | 20a. AUTOPSY? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-28</i> 19 <i>82</i> , to <i>9-29</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>9-28</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>Michael D. Sukrin MD</i> | | DEGREE <i>MD</i> | 22c. DATE SIGNED <i>9-30-82</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael D. Sukrin MD</i> | | 22e. ADDRESS <i>1811 Prince Philip Dr Olney MD</i> | |

| | | | |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | 23b. DATE <i>Oct. 1, 1982</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory Alexandria</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Virginia</i> |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Funeral Homes P/A</i> | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 5 1982</i> | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> |
| 300 W. Montgomery Ave., Rockville, Maryland | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Cleared by DR. FRANCIS MAYLE, M.E. SEPTEMBER 30, 1982

MEDICAL CERTIFICATION

BP

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

DATE: [Illegible]
TO: [Illegible]

FROM: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 1 7 9 | |
|--|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) PHU C PHAM | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-10 1982 | | 2b. HOUR 10 AM | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 5 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Sept. 10 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Viet Nam | | | | 7b. CITIZEN OF WHAT COUNTRY? Permanent Resident | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed | | 12b. KIND OF BUSINESS OR INDUSTRY Fabric Store | |
| 13a. STATE MD | | | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2109 Freeway Lane 20906 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nha Cong Pham | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nhu Thi Nguyen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Nhu K.A. Pham-wife-(same as 13e) | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 2859 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Acute Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal Hem. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) Dep. | | | | DATE SIGNED Sept. 10 1982 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME | | | | ADDRESS 1905 Seminary Road, S.S. Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home 11800 N.H. Avenue Silver Spring, Md. 20904 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | |

First Name

Patronymic (Last Name)

Self (Name)

205-11-11111 (Name as ID)

1905 Secretary Road, S.S. Rd.

11800 N.W. Avenue
Silver Spring, Md. 20904
Cable 1111 (Name)
Burland & Co. (Name)

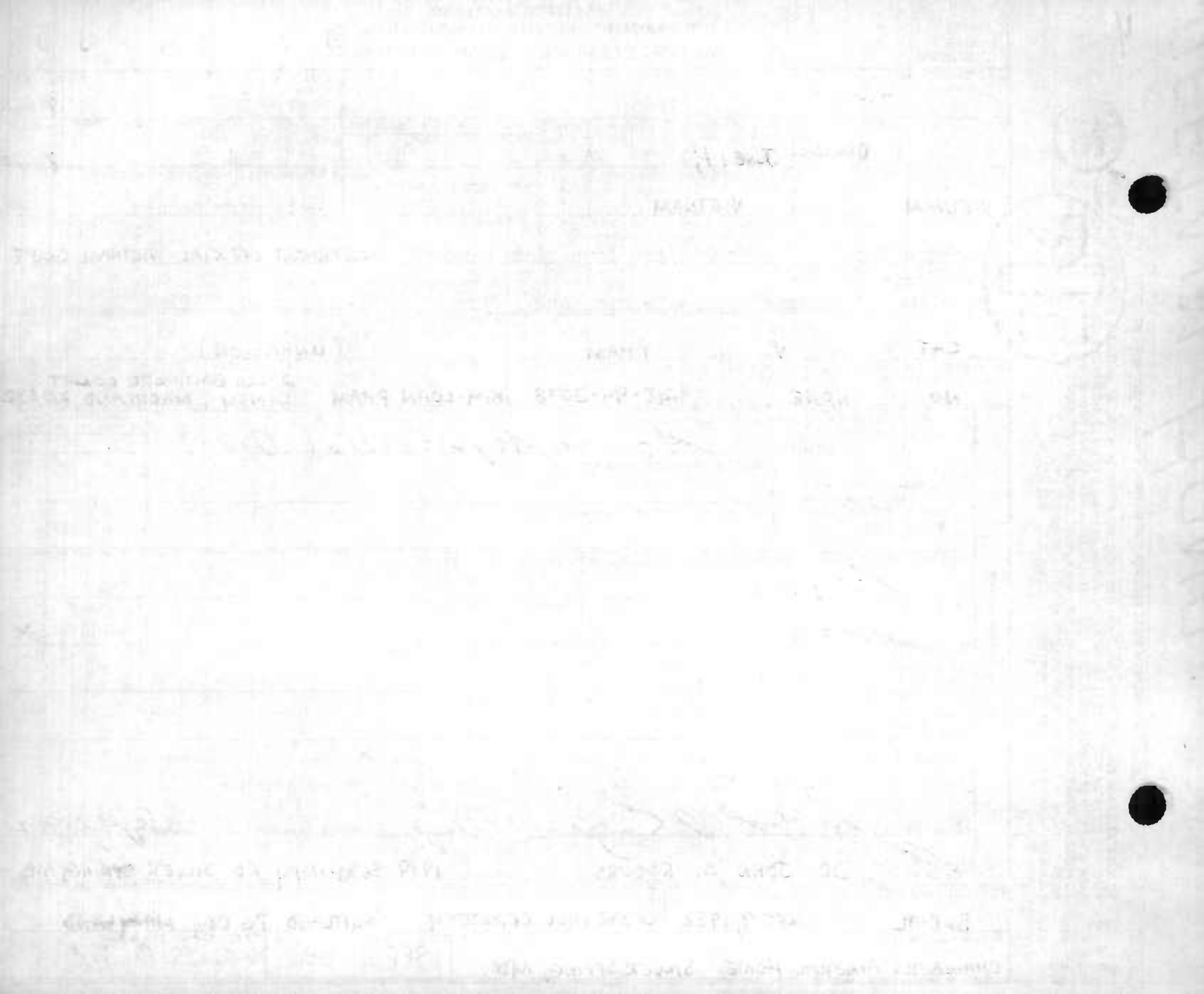
BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24180 | |
|--|--|----------------------------------|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Vanhy nmn Pham | | | | | | 2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> | | 2b. HOUR | | 2c. DATE OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> | |
| 3. SEX male | | 4. RACE ORIENTAL | | 5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> | | 6. AGE (IN YEARS) LAST BIRTHDAY <input type="checkbox"/> | | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | 7. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIETNAM | | | | 7b. CITIZEN OF WHAT COUNTRY? VIETNAM | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GOVERNMENT OFFICIAL | | 12b. KIND OF BUSINESS OR INDUSTRY VIETNAM GOV'T. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 512 Domer Ave #101 | | | |
| 14. FATHER'S NAME FIRST CAT MIDDLE V. LAST PHAM | | | | | | 15. MOTHER'S MAIDEN NAME FIRST (UNKNOWN) MIDDLE (UNKNOWN) LAST (UNKNOWN) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 218-94-3078 | | 17. INFORMANT KIM-LOAN PHAM | | ADDRESS 2 OLD BALTIMORE COURT OLNEY, MARYLAND 20832 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Inf. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | | |
| 19a. DATE OF OPERATION Sept 8 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | | | TITLE (SPECIFY) M.D. | | MEDICAL EXAMINER | | DATE SIGNED Sept 8 1982 | |
| EXAMINER'S NAME (TYPE OR PRINT) DR. JOHN S. ROGERS | | | | | | ADDRESS 1919 SEMINARY RD. SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE SEPT. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, PG. CO. MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | | | ADDRESS SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | |
| | | | | | | REGISTRAR'S SIGNATURE John J. Canale | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 1 8 1

REG. NO.

| | | | | | | | | | |
|---|--|---|----------------------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUIS PILSEN | | | SEPTEMBER 7 1982 | | | 7:05 PM | | | |
| 3 SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 27 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lt. Colonel | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Army | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 137 GRAFTON STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM PILSEN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE ALBERT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII & Korea 108-03-3360 | | 17. INFORMANT ADDRESS LYNNETTE PILSEN, 137 GRAFTON STREET CHEVY CHASE, MD 20815 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 20 , 19 82 , to SEPTEMBER 7 , 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dennis L. Azuma LTJG | | | | DEGREE MD | | | | 22c. DATE SIGNED 08 Sep 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS L. AZUMA, LTJG, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John G. Smith | | | |

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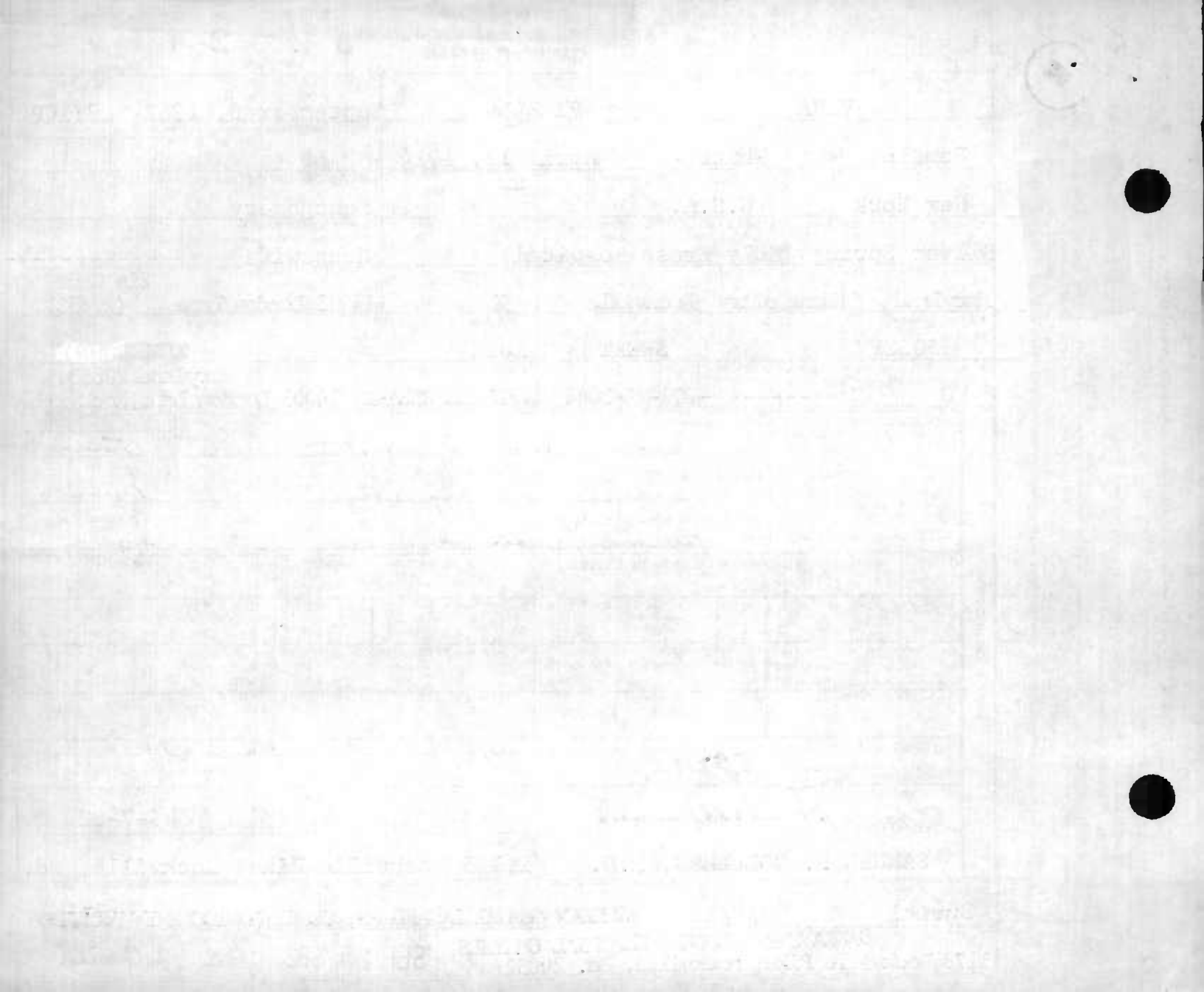
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 1 8 2 | | | | | | |
|--|--|---|--|---|--------------------------|--|-------------------|--|---|---|---------------------|--|----------|----------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | |
| VERA | | | | | PIRELLO | | | | | September 6, 1982 | | | | 9:10PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS. | | | | | | |
| Female | | White | | April 12, 1914 | | 68 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| New York | | U.S.A. | | | | Montgomery MD | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| Silver Spring | | Holy Cross Hospital | | Housewife | | | | | | | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | Zip Code | | | |
| Maryland | | | | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14003 London Lane | | (20853) | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| JOSEPH | | | | | SWEET | | | | | RUTH KOVEL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | | | 071-22-3044 | | | | | Maryland 20853 BERNICE CESARE; 14003 London Lane; Rockville, | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | | 15 min | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic coronary artery</u> | | | | | | | | | | 1 year | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic artery disease</u> | | | | | | | | | | 2 years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1, 1982</u> , to <u>9/6, 1982</u> , that (I) (we) lost saw the deceased <u>alive</u> on <u>8/27/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | | |
| <u>Samuel D. Goldberg M.D.</u> | | | | | | | | 9-7-82 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | | |
| SAMUEL D. GOLDBERG, M.D. | | | | 11125 Rockville Pike; Rockville, Md. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| Burial | | | | 9/8/82 | | JUDEAN MEMORIAL GARDENS; OLNEY; MONTGOMERY; MARYLAND | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | | | | SEP 15 1982 | | | | <u>John J. Conner</u> | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 1 8 3 | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Walter C. Plummer | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13, 1982 | | | | 2b. HOUR 11:40A | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 19, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 11 MONTHS 40 DAYS | | 8. UNDER 74 HRS. HOURS MIN. 40 HRS. 00 MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery' MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hair Dresser | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Damascus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 26030 Mt. Vernon Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Cleveland Plummer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Hardy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 | | 17. INFORMANT Ardelle Plummer, Item 13 | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Cerebral - Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intimate Compression of Prostate DUE TO, OR AS A CONSEQUENCE OF (c) Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 24 HRS 24 HRS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Good Heart, Competitive Nature, Adrenaline, Intermittent Subarachnoid | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/9/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12 E Don Paul Dr. GAITHERSBURG | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 12, 1982 to September 13, 1982 , that (I) (we) last saw the deceased alive on September 12, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE GREGARIO | | | | DEGREE | | | | 22c. DATE SIGNED 9/13/82 | | | | | |
| 22d. PHYSICIAN'S NAME GREGARIO | | | | 22e. ADDRESS 12 E Don Paul Dr. GAITHERSBURG | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Damascus Meth. | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Damascus, Montgomery, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A. | | | | | | ADDRESS Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE Joan J. Conner | | | |

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Office Memorandum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John POOLE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 22 82 | | 2b. HOUR 1918 M | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Damascus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 25504 Woodfield Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willis A. Poole | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Phebus | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO. 218-07-6584 | | 17. INFORMANT ADDRESS Mrs. Mildred Poole (same as above) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC ANEURYSM. 4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) UNDETERMINED APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SKIN ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. | | | | | | | | | |
| 19a. DATE OF OPERATION 9/22/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ABDOMINAL AORTIC ANEURYSM. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 22 19 82, to SEPT 22 19 82, that (I) (we) last saw the deceased alive on 9-22-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD | | 22c. DATE SIGNED 9/22/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIO H. DIAZ MD. | |
| 22e. ADDRESS 18111 PRINCE PHILIP DR. OLNEY MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Mt. Airy, Frederick, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., | | | | ADDRESS Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | |
| | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Riggs Poole | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-30-82 | | 2b. HOUR 4:40 A.M. | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR December 19, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS zip: 20878 301 Russell Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Sprigg Poole | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Evelyn Jones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-60-2313 | | 17. INFORMANT ADDRESS Mrs. Elgin 3384 Cheswick Court, Silver Spring, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.C.H.F. 4140 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Bronchitis, Residue of Stroke, post-op, fx. hip | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 72 to 9-30-82 19 82 , that (I) was did see the deceased alive on 9-29- 19 82 , and that my my (own) opinion death occurred on the date and hour and from the causes stated above. (I) did did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Jack Schumacker M.D. | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED Sept. 30, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacker, M.D. | | | | | 22e. ADDRESS 105 Russell Ave., Gaithersburg, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | ADDRESS P.A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR OCT 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Coniff | |

BP _____

02-32-14

RECEIVED

24 MAR 1942

A. C. H. F.
A. J. H. D.

RECEIVED

24 MAR 1942

RECEIVED

OCT 1 1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 4 1 8 6 | |
|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY MELFORD POPHIN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 19 1982 | | 2b. HOUR 4:00a M |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 3 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | | 13b. CITY OR TOWN PRINCE GEO'S BELTSVILLE | 13c. STREET ADDRESS 11806 MACON STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PAUL POPHAM | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA PAYTON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 1942-1966 725-09-8475 | | 17. INFORMANT ADDRESS ROBERTA A. POPHIN, 11806 MACON STREET, BELTSVILLE, MD 20705 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7420 IMMEDIATE CAUSE (a) BRAIN HERNIATION | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 3 19 82 , to SEPTEMBER 19 19 82 , that (I) (we) lost saw the deceased alive on SEPTEMBER 19 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE R. K. Ferguson LT, MC, USNR | | | | 22c. DATE SIGNED 20 Sept 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. FERGUSON, LT, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Carrollton City Cemetery | |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND | | 23d. LOCATION CITY OR TOWN COUNTY STATE Carrollton Georgia | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Givens | | | | | |

10-11-11

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.
JAN 11 1911



2-10-11-11

CO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. 8 2 2 4 1 8 7 | |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| CLARA IRMA POSER | | 9 26 82 | | 2:17 P | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| FEMALE | WHITE | JAN. 10, 1892 | 90 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| GERMANY | USA | | MONTGOMERY CO. MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| ROCKVILLE | NATIONAL LUTHERAN HOME | | HOMEMAKER | | NONE |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | BALTIMORE | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| MAX POSER | | ELIZABETH GROSS | | 707-GLENWOOD AVENUE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 212-32-2320 | | REV. DR. RICHARD REI CHARD - NIH- ROCKVILLE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| 4039 IMMEDIATE CAUSE (a) Renal failure | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DO TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis | | | | | |
| DO TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| Tumor of lung. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov 13 1980 to Sept 26 1982, that (I) (we) lost saw the deceased alive on Sept 26 1982, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Harold F. McCann | | M.D. | | 9-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| HAROLD F. MCCANN | | 3355-16th St. N.W. WASH. D.C 20010 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | SEPT. 27/82 | | CEDAR HILL CREMATORY | |
| 24. FUNERAL DIRECTOR NAME | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 25a. DATE REC'D. BY REGISTRAR | |
| HYSONG CO., 1300- N ST., NW WASH., DC | | SUITLAND, MARYLAND | | OCT 4 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | John J. Carver | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR A CEMETERY. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24188 | | | |
|--|--|-----------------------|---|--|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Remyx2 Bridget Pothuvilage | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH 9 DAY 20 YEAR 1982 | | | |
| 3. SEX F | | 4. RACE Indian | | 5. DATE OF BIRTH MONTH 04 DAY 23 YEAR 1943 | | 6. AGE (IN YEARS) MONTHS 39 YEARS 39 | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | | 7c. DATE PRONOUNCED DEAD MONTH 9 DAY 20 YEAR 1982 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Tak. Park | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wes h. Advent Hosp | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Spz | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9320 Walden Rd | | | |
| 14. FATHER'S NAME FIRST Samuel MIDDLE G. LAST Mendis | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE C. LAST Ferdinando | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-86-1052 | | 17. INFORMANT Gita Dhillon ADDRESS 6401 Winnepeg Rd. Bethesda, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drug Overdose 9504 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 9 26 02 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Overdose My to 1 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) None | | 21f. LOCATION STREET Walden Rd CITY OR TOWN Spz COUNTY Mont STATE MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John L. Rogers M.D. Rogers | | | | | | TITLE (SPECIFY) MEDICAL EXAMINER | | | DATE SIGNED Sept 20 1982 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 9/22/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Med. School | | | 23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME Columbia Mortuary Services, Inc. ADDRESS 225 Missouri Ave. NW Washington, D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Caniff | | | | | |

DECLASSIFIED

Info

U.S.A.

General

C. G. Gendie

James

J.

Washington

No

275-66-1052

With Million Bethe, Maryland
6001 Wisconsin St.

MAILED

Removal of Gov. Geo. Wash. Schol

Columbia University, New York, N.Y.

Washington, D.C.

225 Mission Ave. N. Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | 7 2 2 4 1 8 9 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Elsie | | MIDDLE Mae | | LAST Pratt | | 2a. DATE OF DEATH MONTH DAY YEAR September 9, 1982 | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR April 7, 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | | 7b. HOUR P 4:35 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center (NIH) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSING APT | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Washington, DC | | 13b. CITY OR TOWN Washington, DC | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4420 - 3rd St., SE, Apt. 8 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sidney Davis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Parkham | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | |
| 16b. SOCIAL SECURITY NO. 237-52-1112 | | 17. INFORMANT ADDRESS Mr. John Pratt, husband, 2705 Stanton Rd. SE, Washington, DC 20020 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 24 Hours 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiogenic Shock</u> 24 Hours (c) <u>Breast Cancer</u> 18 Months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (if this hospital) attended the deceased from <u>September 7, 1982</u> , to <u>September 9, 1982</u> , that <u>X</u> (we) lost <u>the deceased</u> <u>above</u> <u>(we)</u> (did) <u>not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Carmen Allegra</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/10/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carmen Allegra, MD | | 22e. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Mt | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md | | | |
| 24. FUNERAL DIRECTOR NAME Vann & Williams Funeral Home, Wash., D.C. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John</u> | | | |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

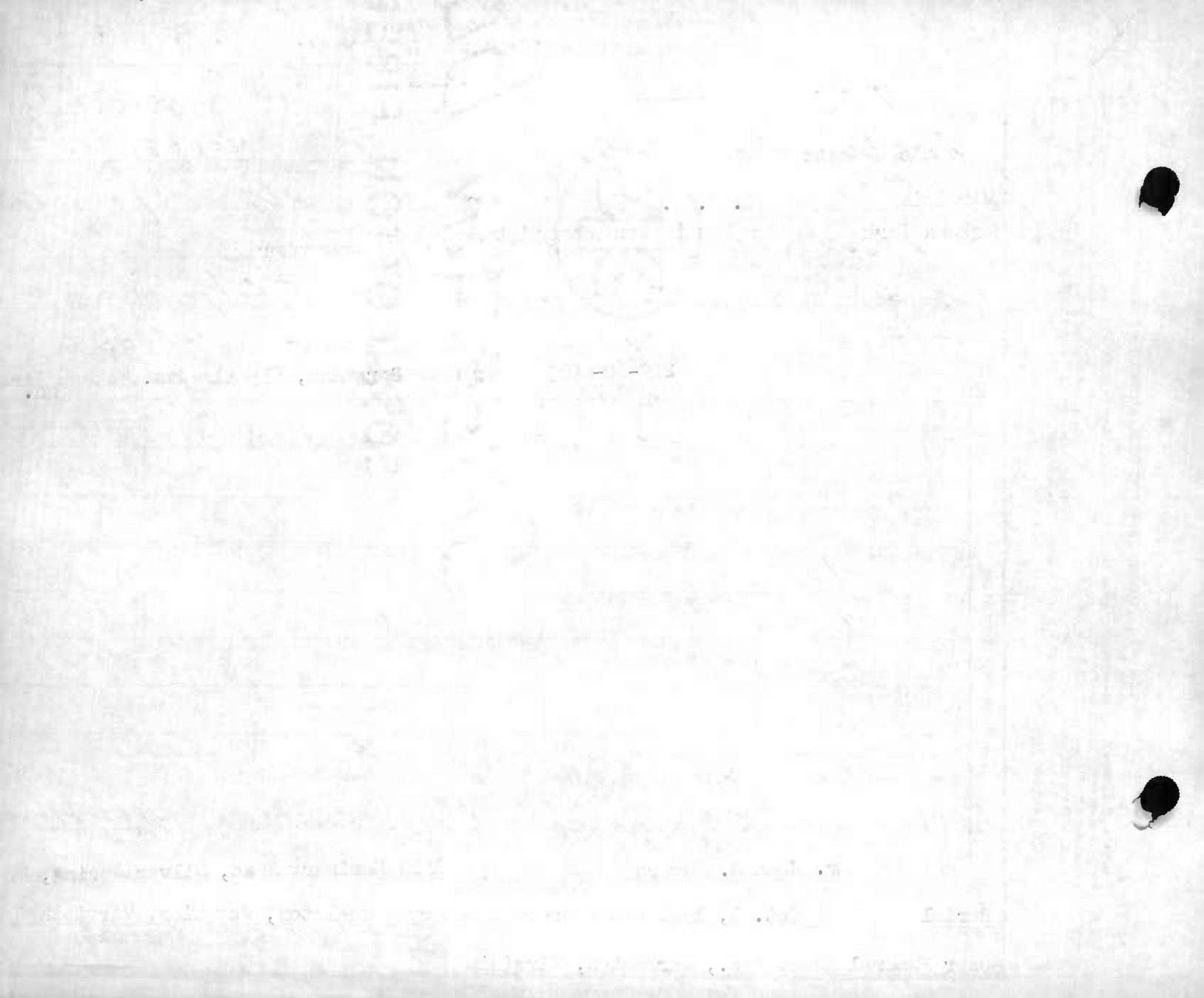
MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 1 9 0 REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST GLADYS | | MIDDLE D. | | LAST PRATT | | 2a. DATE OF DEATH MONTH DAY YEAR 9-21-82 | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 19 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSSES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN WHEATON | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry A. Dalmas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Walter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-36-9337 | | 17. INFORMANT Joyce Ann Pratt 10955 Bucknell Dr. Wheaton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral pulmonary event</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:30 P.M. 9-21-82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (u) (this hospital) attended the deceased from 9-20-82, 1982, to 9-21-82, 1982, that (u) (we) last saw the deceased alive on 9-19-82, 1982, and that (u) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Norman S. Kougel | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-21-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman S. Kougel | | | | 22e. ADDRESS 8750 Georgia Ave Silver Spring, MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME David L. Sauers Funeral Home, Falls Church, Va | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24191 | |
|--|----------------------|--|-----------------------------|--|--------------------------------|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) IVA CORDER PRICE | | 2a. DATE OF DEATH Sept 28 1982 | | 2b. HOUR OF DEATH 8:00 PM | | 2c. DATE OF DEATH Sept 28 1982 | | 2d. TIME OF DEATH 8:00 PM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Feb. 23 1922 | 6. AGE (IN YEARS) 60 | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 11. KIND OF BUSINESS OR INDUSTRY | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 11. KIND OF BUSINESS OR INDUSTRY | |
| 11. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, STATE AT WHAT PLACE AND DATE) Washington Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE MD | | 13b. COUNTY Tak. Park | |
| 13a. STATE MD | | 13b. COUNTY Tak. Park | | 13c. CITY OR TOWN Tak. Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 615 Elm Ave. | | 14. FATHER'S NAME Alfred | |
| 14. FATHER'S NAME Alfred | | 15. MOTHER'S MAIDEN NAME Margaret | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 229-60-9013 | | 17. INFORMANT Frances Bergmann | | 18. ADDRESS 615 Elm Ave., Takoma Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | 19. DATE OF OPERATION None | | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. DATE Oct. 1, 1982 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery | | 22d. LOCATION CITY OR TOWN COUNTY STATE Bealeton, Fauquier, Virginia | | 23. ACTUAL SIGNATURE Dr. John S. Rogers | | 24. DATE REC'D. BY REGISTRAR Oct 1 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bealeton, Fauquier, Virginia | | 24. FUNERAL DIRECTOR NAME Moser Funeral Home, Inc., Warrenton, Virginia | | 25. REGISTRAR'S SIGNATURE John S. Rogers | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to attend.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 1 9 2 | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND PERRY PRICE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 4 82 | | 2b. HOUR 10 AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Clarksburg | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Vernon Price | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Mae Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-7829 | | 17. INFORMANT ADDRESS Bedford Dodson, 25800 Frederick Road, Clarksburg, Md. 20871 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE 5850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). RECURRENT URINARY TRACT INFECTION; CONGESTIVE HEART FAILURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from Feb 10, 1981 to SEP 4, 1982 , that (1) (we) last saw the deceased alive on SEP 4, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) see the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Martin C. Shakel | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> | | 22c. DATE SIGNED 9/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHAKEL | | | | 22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON MD-20895 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Hyattstown Methodist Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hyattstown, Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE John J. ... | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 1 9 3 | |
|--|--|--|--|---|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE MARK PRIOR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16 1982 | | | 2b. HOUR 3:45 am | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 15 1952 | | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. NAVY LT. | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA | | | | | 13b. CITY OR TOWN ARLINGTON | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 965A S. ROLFE STREET | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JAMES PRIOR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATHILDA HILSDORF | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1974-1982 | | 17. INFORMANT LIZA BETH R. PRIOR | | ADDRESS 965A S. ROLFE STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATING PNEUMONIA</u> DUO TO, OR AS A CONSEQUENCE OF (b) <u>TOXIC EPIDERMONECROLYSIS</u> DUO TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 5</u> , 19 <u>82</u> , to <u>SEPTEMBER 16</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>SEPTEMBER 16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 16 Sep 82 | |
| 22b. SIGNATURE <u>Dennis L. Azuma</u> LT MC USNR | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS L. AZUMA, LT, MC, USNR | | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE SEPT. 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARLINGTON, VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | | ADDRESS SILVER SPRING, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 4 1 9 4 |
|---|--|--|--|--|--|---|--|--|--|---------------|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. |
| 1. DECEASED NAME (TYPE OR PRINT) Elsie Pychnery. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR 7:20 AM | | |
| 3. SEX Female. | | 4. RACE White. | | 5. DATE OF BIRTH MONTH DAY YEAR 8-15-1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD. | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital, Bethesda, Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORK IN LIFE) House Wife. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland. | | | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Kensington. | | 13d. STREET ADDRESS 2700 Barker Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | | | 16b. SOCIAL SECURITY NO. 220-54-7705 | | 17. INFORMANT ADDRESS Nephew. Glenwood, Md. 21738 Edward Pelsinsky. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1539 2 days unknown | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, Schizophrenia | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1915 , 19____, to 9/20/82 , 19____, that (I) (we) lost saw the deceased alive on 9/20/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Jeremy V. Cooke | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke. | | | | | 22e. ADDRESS 10400 Conn. Ave. Kensington, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation. | | | 23b. DATE Sept. 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Rd. P. G. Co., | | | |
| 24. FUNERAL DIRECTOR Takoma Funeral Home. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | |
| 25c. ADDRESS 254 Carroll St. N. W. D. C. | | | | | | | | | | |

Jerome V. Cooke.
1982
Cromwell, Sept. 22, St. Lincoln.
Takoma Funeral Home.
222 Carroll St. N. W. C.

590

St. Louis, Mo. 63101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 1 9 5 REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Irma M Quick | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 82 | | 2b. HOUR 2:45 A.M. | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 8 28 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 20014 | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5225 Pooks Hill Rd. Apt. #416N. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis McPherson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Ruem | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 075-10-3804B | | 17. INFORMANT Mitchell Quick | | ADDRESS 5225 Pooks Hill Rd. Apt #416N. Bethesda, Maryland 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 0381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococcal Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) infected right hip prosthesis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Polymyeloma Rheumatic, Gastrointestinal bleeding | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/22/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED hip prosthesis | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10400 Conn Ave, 16ans Rockville Montgomery Md. | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22/82 , 19____, to 9/23/82 , 19____, that (I) (we) last saw the deceased alive on 9/22/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 9/23/82 | |
| 22b. SIGNATURE Jeremy V Cooke | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke | | | | 22e. ADDRESS 10400 Conn Ave, 16ans | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. | | | | ADDRESS 1331 Rockville Pike Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | |

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1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter is a copy of the original, which is in the possession of the Library of Congress.

2. The second part of the document is a letter from the Secretary of the Treasury to the President, dated January 1, 1863. The letter is signed by Alexander C. Harris and is addressed to the President. The letter is a copy of the original, which is in the possession of the Library of Congress.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 4 1 9 6
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HERBERT B REED JR. | | 2a. DATE OF DEATH MONTH 9 DAY 27 YEAR 82 | | 2b. HOUR 9:45* | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HSP | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIST | | 12b. KIND OF BUSINESS OR INDUSTRY NAVAL SURFACE WEAPON | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | |
| 14. FATHER'S NAME FIRST HERBERT MIDDLE B. LAST REED, SR. | | 15. MOTHER'S MAIDEN NAME FIRST GERTRUDE MIDDLE E. LAST GRANT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 050-07-2457 | | 17. INFORMANT ADDRESS DORIS C. REED SAME AS 13 WIFE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) total occlusion DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 2 , 19 82 , to SEPT 27 , 19 82 , that (I) (we) last saw the deceased alive on 9/27/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Arthur Wilets | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR WILETS | | 22e. ADDRESS 1111 SPRING STREET, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY MT. ZION | |
| 23d. LOCATION (CITY OR TOWN) HIGHLAND HOWARD MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-455-9

RECEIVED B REED JR

11 18 85

17

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100-455-9

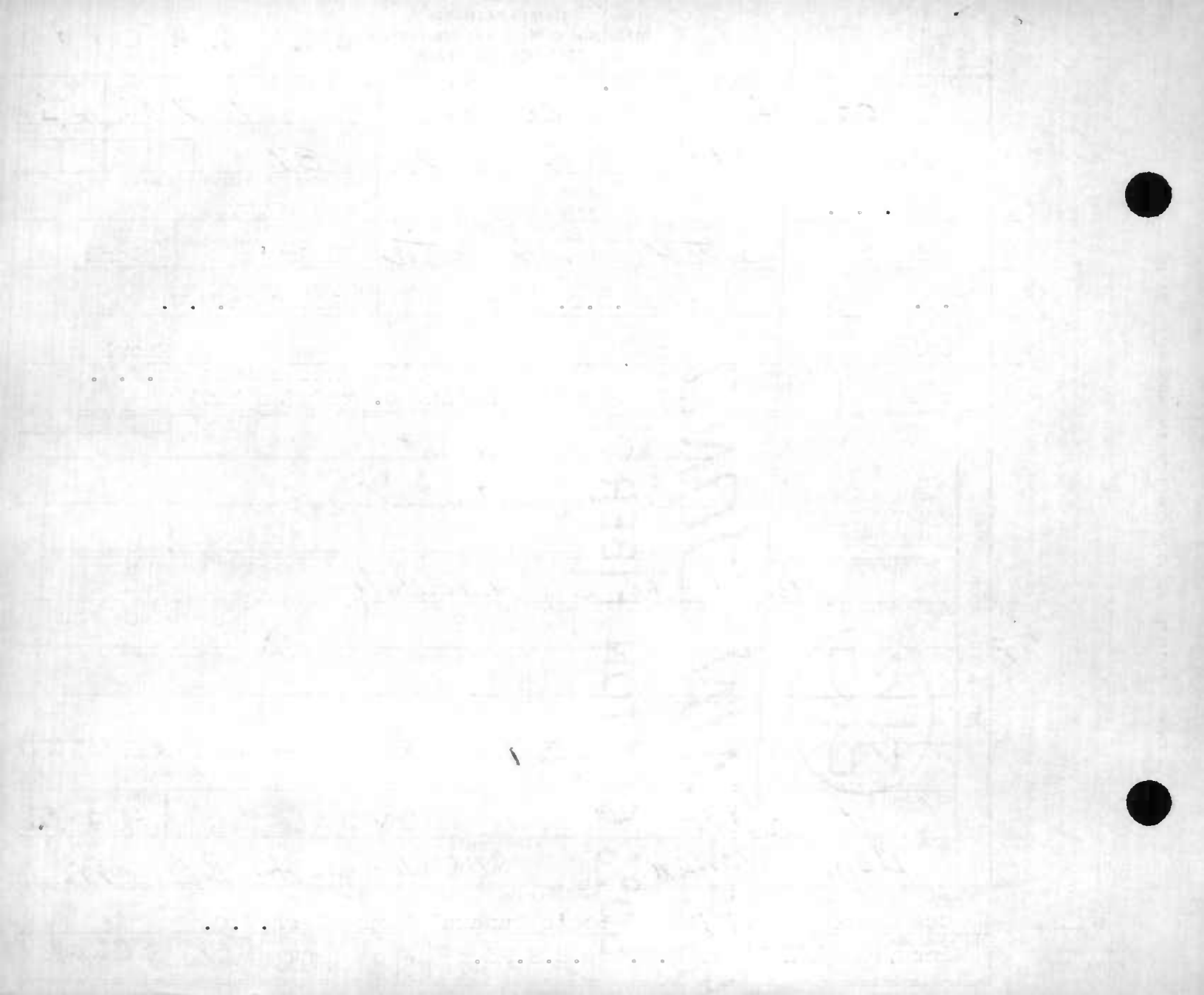
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 2 4 1 9 7 | |
|--|--|---|--|---|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Robert H. Reed | | | | | 2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 82 | | | | | 2b. HOUR 12:40 M | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash.D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Bethesda Health Center | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY Clerk | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. | | | | | 13b. CITY OR TOWN Wash.D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2134 G St.N.W. | | |
| 14. FATHER'S NAME FIRST Louis MIDDLE LAST Reed | | | | | 15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST Knowles | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. 577 60 0369 | | 17. INFORMANT 3118 Rittenhouse St.N.W. William O. Brady (Nephew) | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pleural effusion. Malnutrition | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 82 , to 9-7 , 19 82 , that (I) (we) lost saw the deceased alive on 8-15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H. Baha MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 9-7-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAN | | | | | 22e. ADDRESS 8218 Wisconsin Ave. Beth. MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Funeral Home | | | 23d. LOCATION CITY OR TOWN Wash.D.C. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Hines/Rinaldi 11800 N.H.Ave.S.S.Md. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the next 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 2 4 1 9 8 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HARRY HARRY R. REIDINGER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR September 1, 1982 9:15 P.M. | | | |
| 3. SEX male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 15, 1881 | | 6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAILOR | | 12b. KIND OF BUSINESS OR INDUSTRY CLOTHING | |
| 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10,000 NEW HAMPSHIRE AVENUE | |
| 14. FATHER'S NAME (UNASCERTAINABLE) REIDINGER | | | | 15. MOTHER'S MAIDEN NAME (UNASCERTAINABLE) ZLATA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 516-36-4704 | | 17. INFORMANT ADDRESS JOSEPH REIDINGER, 8917 WHITNEY STREET, SILVER SPRING, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA - MILD | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 to 9/1/82 , that (I) (we) last saw the deceased alive on 9/1/82 , and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE D. J. Patel | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. J. PATEL, M.D. | | 22e. ADDRESS 6131 MONTROSE RD. ROCKVILLE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 9/3/1982 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY | | 23d. LOCATION ADELPHI, PR. GEORGES, MD. | |
| 24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | | | 24a. DATE RECEIVED BY REGISTRAR SEP 8 1982 | | | |
| 24b. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | |

RECEIVED
FEB 10 1964

MEMORANDUM
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

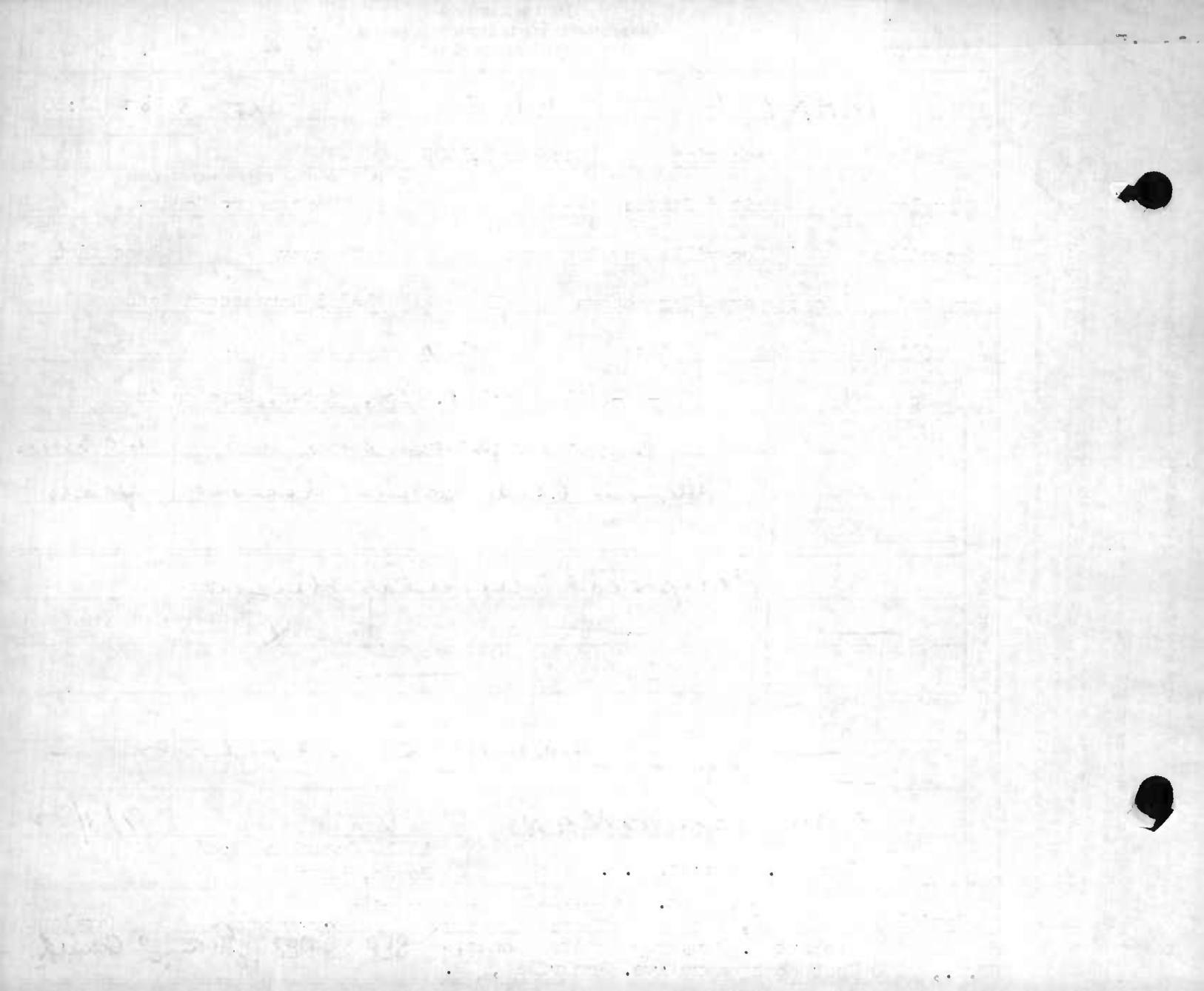
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 1 9 9 REG. NO. | |
|--|--|---|--|--|--|--|--|---|--|---------------------------|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) CALVIN ARTHUR REYNOLDS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 1 1982 | | 2b. HOUR 2 15 P M | | | |
| 3 SEX Male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR 3 27 27 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 211 Croydon Avenue | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired electrician | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE Maryland | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Rockville | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 211 Croydon Avenue | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Harry Reynolds | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hill | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 211 12 9270 | | 17 INFORMANT ADDRESS Bertha Reynolds same as 13e | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Colon Cancer 1539 DUE TO, OR AS A CONSEQUENCE OF With distant metastasis (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 19 80 to 9/1/82, 19 82, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Frauke Westphal | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 9/1/82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal | | | | 22e ADDRESS 809 Viers Mill Road Rockville, Md. 20851 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL 15 SEP 82 Burial | | 23b DATE 9/5/82 | | 23c NAME OF CEMETERY OR CREMATORY Blough Menonite Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Conemaugh Twp. Somerset, Pa. | | | | | |
| 24 FUNERAL DIRECTOR Lyon Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | 25a DATE REC'D. BY REGISTRAR SEP 7 1982 | | | | | | | |
| | | | | 25b REGISTRAR'S SIGNATURE John J. Calkins | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 | | 2 4 2 0 0 | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MARY A | | MIDDLE | | LAST RICE | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | Caucasian | | October 1, 1893 | | 88 YRS. | | | | 12:30 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | United States | | | | Montgomery County, MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | Rockville Nursing Home | | | | Teacher | | Education | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Germantown | | | | 14151 Darnestown Road | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Millard Lee Rice | | | | Nellie Kelley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| No | | | | 219-36-8411 | | Bennie N. Rice, Sister, Same as item #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>3989</u> <u>Bronchopneumonia</u> | | | | | | | | | | 48 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Phemuric Cardiac vascular disease</u> | | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Peripheral vascular disease</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) <u>John S. Fawcett</u> attended the deceased from <u>March 21</u> , 19 <u>53</u> , to <u>Sept 2</u> , 19 <u>82</u> , that (I) <u>(lost)</u> saw the deceased alive on <u>Sept 2</u> , 19 <u>82</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did not)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| John S. Fawcett | | | | | | | | | | 9/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| John S. Fawcett, M.D. | | | | | | | | | | 16610 Sugarland Road Boysds, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | Sept. 5, 1982 | | Darnestown Presbyterian Church Cemetery | | Germantown | | Montgomery | | Maryland | |
| 24 FUNERAL DIRECTOR NAME | | | | | | | | | | | |
| Robert A. Pumphrey, P.A., 300 West Montgomery Ave. Rockville, MD. | | | | | | | | | | | |
| 25a. DATE RECD. BY REGISTRAR | | | | | | | | | | | |
| SEP 9 1982 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| John S. Fawcett | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 42 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

2 4 2 0 1

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) ELISABETH SHARP RILEY | | | 2a. DATE OF DEATH Month SEPTEMBER Day 21 Year 1982 | | | 2b. HOUR 10:00 A M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH FEBRUARY 5, 1907 | | 6. AGE (In years last birthday) 75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1625 MAYDALE DR. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TECHNICAL EDITOR | | 12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPG. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last JOHN R. SHARP | | 15. MOTHER'S MAIDEN NAME First Middle Last MARGARET E. OTIS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | |
| 16b. SOCIAL SECURITY NO. 579-52-9910 | | 17. INFORMANT MARGARET CATON, DAUGHTER Add 722 GULPH ROAD WAYNE, PA. 19087 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Candine arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY , 19 82 , to SEPT 21 , 19 82 , that (I) (we) last saw the deceased alive on SEPT 21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Neal Rosen | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/21/82 | |
| 22d. PHYSICIAN'S NAME (Type) NEAL ROSEN, M.D. | | 22e. ADDRESS NAVEL HOSPITAL, BETHESDA, MD. 20814 | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL CREMATION | | 23b. DATE 9/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION (City or Town) (County) (State) SUITLAND PG. MD. | |
| 24. FUNERAL DIRECTOR R & R CREMATION SERVICES 3520 CONNECTICUT AVE., N.W. WASH. D.C. 20008 | | | | 25a. REC'D BY REGISTRAR DATE SEP 24 1982 | | 25b. REGISTRAR'S SIGNATURE John G. Smith | |

RECEIVED
FBI
JAN 14 1964

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]
[illegible]

DATE: [illegible]
[illegible]

100-3-111
[illegible]

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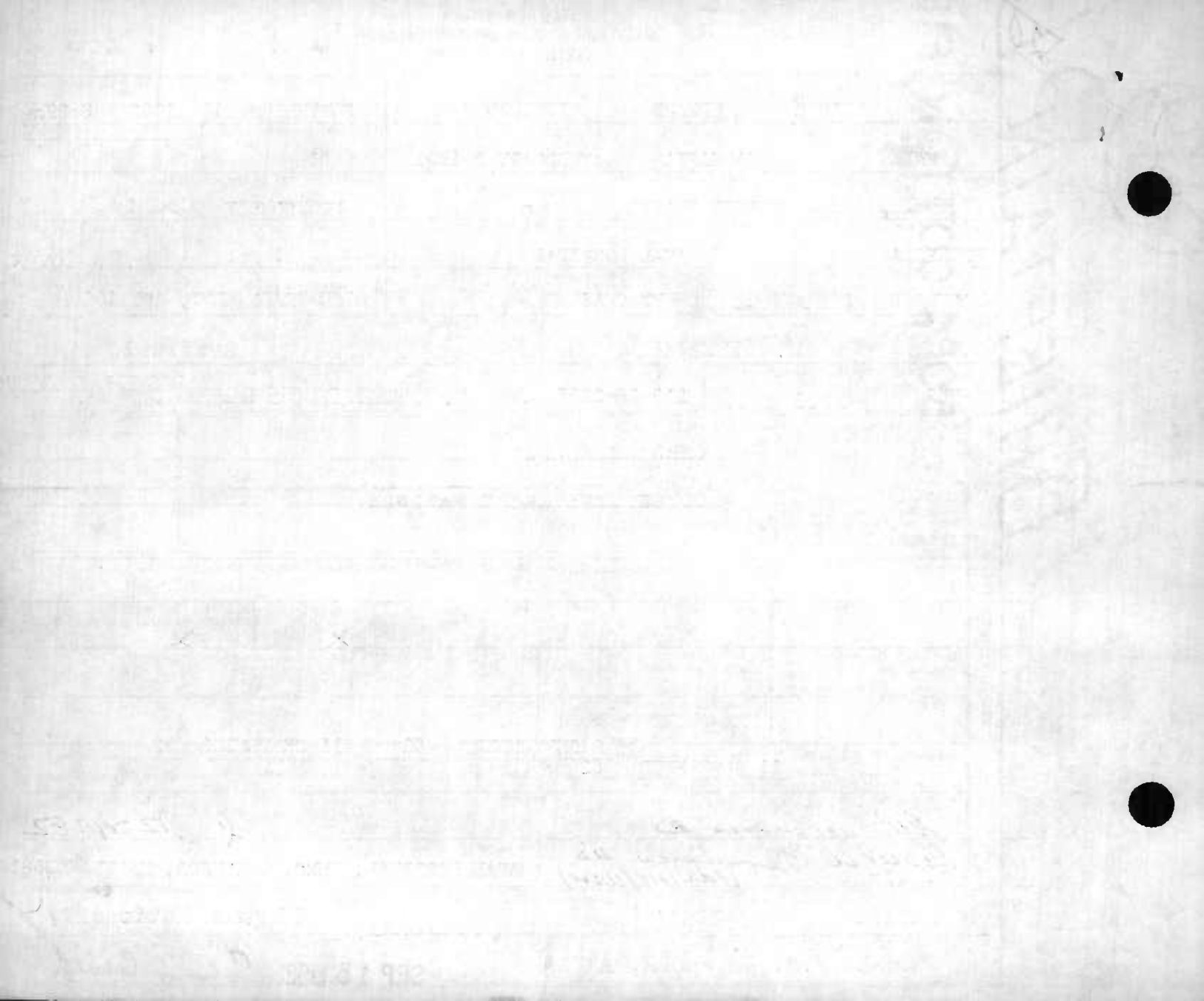
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 82 24202 | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISIDOR EDWARD RITTENBURG | | | | | 2a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11 1982 | | | 2b HOUR 8:29am | |
| 3 SEX MALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH MONTH DAY YEAR FEBRUARY 5 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | 7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS | | 7b CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD. | | | |
| 10 CITY OR TOWN OF DEATH BETHESDA | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Military U.S. Gov't | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MARYLAND | | 13b COUNTY MONTGOMERY | | 13c CITY OR TOWN CHEVY CHASE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 4700 BRADY BLVD, APT 101 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JACOB H. RITTENBURG | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1923 1959 | | 17 INFORMANT JOHN G. RITTENBURG | | ADDRESS 315 SADDLE LAKE DR. ROSWELL, GA. 30070 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6 SEPTEMBER 1982</u> to <u>11 SEPTEMBER 1982</u> , that (I) (we) lost saw the deceased alive on <u>11 SEPTEMBER 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <i>Robert A. Timmons</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED 12 Sept 82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) R. TIMMONS | | 22e ADDRESS NAVAL HOSPITAL, NNMC, BETHESDA, MARYLAND 20814 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Sept. 14, 1982 | | 23c NAME OF CEMETERY OR CREMATORY Arlington National | | 23d LOCATION CITY OR TOWN COUNTY STATE Arlington National | | | |
| 24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., BETHESDA, MARYLAND | | | | 25a DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b REGISTRAR'S SIGNATURE <i>James J. Connelley</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 0 3 REG. NO. | | | | |
|--|--|--|--|--|--|---|--|---------------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REGINA ROSNER | | | | September 7, 1982 | | | | 11:57A |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR August 20, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 85 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 74 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MOSES FOSNER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GITTEL (UNKNOWN) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 215-56-9636T | | 17. INFORMANT ADDRESS Florence Schwartz; 12519 Montclair Drive | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL DISEASE - ACUTE FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIO VASCULAR DISEASE | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW HOURS 5-7 DAYS SEVERAL YEARS | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, COPD, CEREBRAL VASCULAR ACCIDENT | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 7, 1982 to SEPT. 7, 1982 , that (I) (we) last saw the deceased live on SEPT. 7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | | | | |
| 22b. SIGNATURE Lawrence D. Marcus, M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/7/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE D. MARCUS, M.D. | | | | 22e. ADDRESS 1111 SPRING STREET, SILVER SPRING, MARYLAND 20910 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GDN. FALLS CHURCH, MONTGOMERY, MD. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1982 John J. Conner | | | | |
| 24. FUNERAL DIRECTOR NAME 1170 Rockville Pike; Rockville, Md. | | | | | | | | |

MEDICAL CERTIFICATION

99

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
530 SOUTH EAST ASIAN AVENUE
CHICAGO, ILLINOIS 60607
TEL: 773-936-5000
FAX: 773-936-5001
WWW.CHEM.UCHICAGO.EDU

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

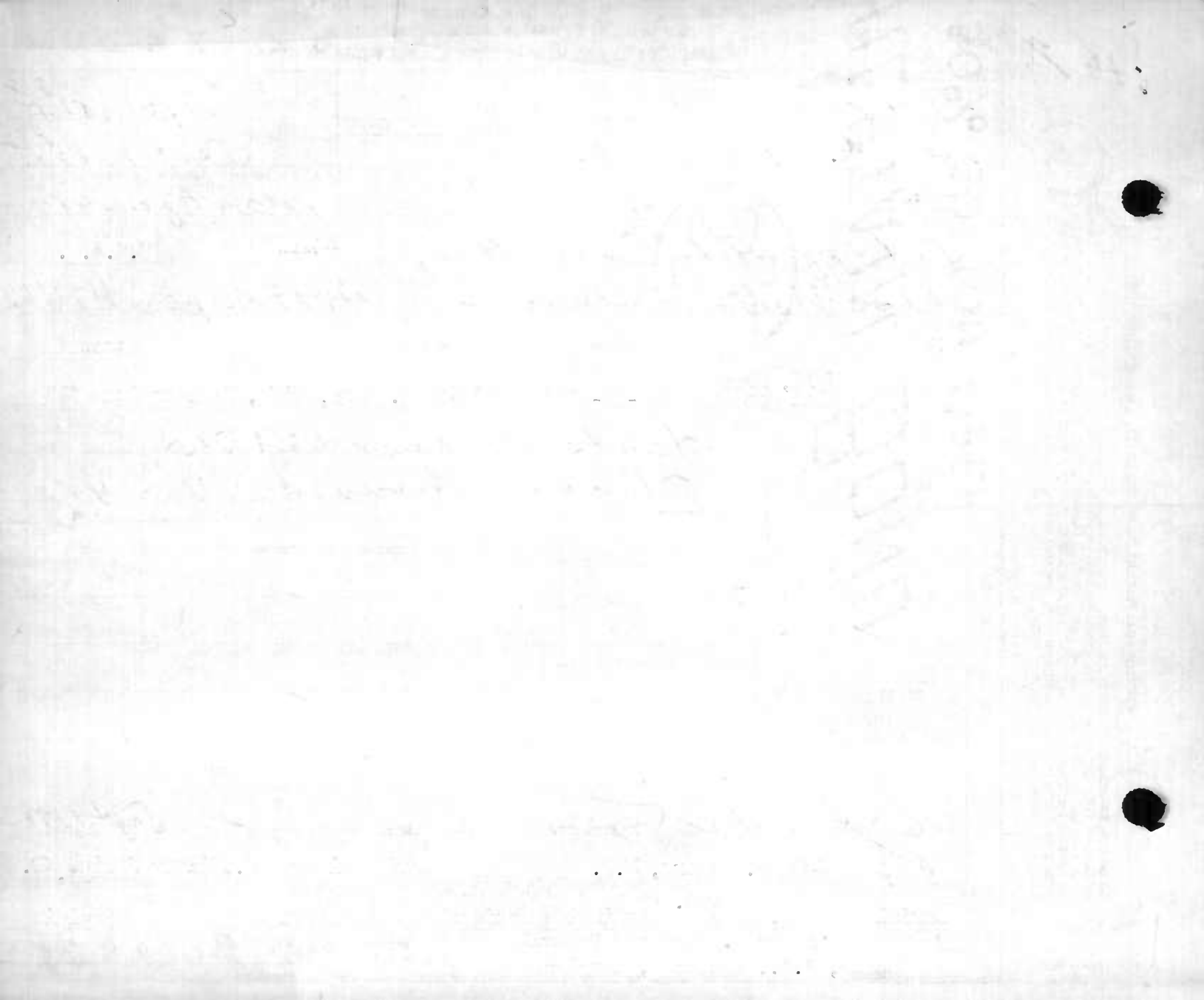
[illegible text follows]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR 15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 2 0 4 | |
|--|-------------------------|---|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anello P. Ross | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH Sept DAY 1 YEAR 1982 | |
| 3. SEX Male | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH July DAY 21 YEAR 1916 | 6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD MONTH Sept DAY 1 YEAR 1982 | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Sgt. Sp. Holy Cross Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Major | | 12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F. | |
| 10. CITY OR TOWN OF DEATH Sgt. Sp. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Sgt. Sp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Major | | 12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F. | | 13a. STATE MD. | | 13b. CITY OR TOWN Rockville | |
| 14. FATHER'S NAME FIRST Philip MIDDLE Ross LAST Rossetti | | 15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE Rossetti LAST Rossetti | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 573-12-8138 | | 17. INFORMANT Elaine W. Ross, Wife, Same as item #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 4291 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) M.D. | | MEDICAL EXAMINER John S. Rogers | | | | DATE Sept. 1, 1982 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | ADDRESS 1919 Seminary Rd., Silver Spring, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | 23d. LOCATION CITY OR TOWN Arlington COUNTY Virginia STATE Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 7 2 2 4 2 0 5 | |
|--|--|---|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST x GEORGE W. ROTHMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-28-82 | | | | | 2b. HOUR 1712 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) x SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C.P.A. | | 12b. KIND OF BUSINESS OR INDUSTRY Accounting | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Potomac | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6 Green Lane Court | | Zip Code: 20854 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Rothman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hermira Rubinstein | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean | | 17. INFORMANT Maryland 20815 Martin Silver; 2915 Greenvale St.; Chevy Chase, | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) <u>Cardiomyopathy Aortic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12, 19 82, to 9/24, 19 82, that (I) (we) last saw the deceased alive on 9/24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Daniel Goldberg | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/28/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Goldberg | | | | | 22e. ADDRESS 10401 Old Georgetown Rd Bethesda, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn; Falls Church; Fairfax; Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 0 6 | |
|---|--|---|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROGER FREDERICK ROWE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-26-82 | | 2b. HOUR 3:42AM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2-11-14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH mont. County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) THERAPIST | | 12b. KIND OF BUSINESS OR INDUSTRY HOLY CROSS HOSPITAL | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN S. ROWE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY E. GOULD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 106-03-8842 | | 17. INFORMANT COUSIN | | ADDRESS 108 HARMONY ROAD MICKLETON, NEW JERSEY | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Perforation of colon (the sigmoid perforations) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 10 day | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Paraplegia - lower extremities | | | | | | | | | | | |
| 19a. DATE OF OPERATION Sept 7 1982 Sept 24 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid perfracture. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from November 16, 1967 to September 26, 1982 , that (I) (we) lost saw the deceased alive on September 25, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Clorn H. Traum MD | | | | | | DEGREE MD | | 22c. DATE SIGNED September 26, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AARON H. TRAUM MD | | | | | | 22e. ADDRESS 8915 Georgia Ave Silver Spring Md 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR NAME RANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT. 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 0 7 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST JOHN FREDERICK ROXBURY, SR. | | | | 2b. HOUR 9:30 a.m. | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 25 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 62 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EN 2 | | 12b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | |
| 13a. STATE RHODE ISLAND | | | | 13b. COUNTY NEWPORT | | 13c. CITY OR TOWN NEWPORT | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 5cc ROLLING GREEN, 02840 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK ROXBURY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE COLLINS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1939-1960 | | 17. INFORMANT ADDRESS JOHN F. ROXBURY, JR., Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2859 IMMEDIATE CAUSE (a) Respiratory failure, 2° to pneumonia / doed DUE TO, OR AS A CONSEQUENCE OF (b) Refractory anemia & excess blast cells DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 4, 1982 , to SEPTEMBER 21, 1982 , that (I) (we) lost saw the deceased alive on SEPTEMBER 21, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN <i>Marion R. McMillan</i> | | | | DEGREE M.D. | | 22c. DATE SIGNED 22 Sept 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARION R. MCMILLAN, LT, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE September 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rhode Island Veteran's Cemetery | | 23d. LOCATION Exeter, Washington Co., R.I. | |
| 24. FUNERAL DIRECTOR NAME Ives Funeral Home Arlington, Va | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Joan J. Connel</i> | |

BP

BP
DHMH - 16 50M 1/BI
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 0 8 REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|-----------------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dana Hansford Rule | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/6/82 | | | | 2b. HOUR 12:40 M | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 12 4 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. TRANSIT OPERATOR | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MACK G. RULE | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA M. GROSE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT LORETTA M. RULE | | ADDRESS SAME AS 13 | | WIFE | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Severe Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Severe Chronic Obstructive Pulmonary Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 30 min Several hrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31/82 to 9/6/82 , that (I) (we) lost 9/5/82 saw the deceased alive on 9/5/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE David Cromwell MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22f. DATE SIGNED 9/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID CROMWELL | | | | | | 22e. ADDRESS SILVER SPRING, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY ST. GEORGES CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE VALLEY LEE ST. MARYS MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Davis | | | | | |

U. S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

RECEIVED



George C. Smith

SEP 10 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 0 9 | |
|--|--|---|--|--|---|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Grace Russ | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/30/82 | | | 2b. HOUR 1245 PM | | | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1886 | | 6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Person | | 12b. KIND OF BUSINESS OR INDUSTRY Millinery | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6121 Montrose Road Zip Code: 20852 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lester Paslavsky | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mina (Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 083-18-2441A | | 17. INFORMANT Falls Church, Va 22041 Martin Bruce; 3701 So. George Mason Dr.; | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Possible myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/12/78 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6121 Montrose Rd. Rockville, Md. | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/12/78 to 9/30/82 , that (I) (we) last saw the deceased alive on 9/30/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H. D. Khawanez | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/30/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. D. KHAWANEZ | | | | 22e. ADDRESS 6121 Montrose Rd. Rockville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cemetery; Pinelawn, L.I., N.Y. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | |

BP _____

Handwritten notes and faint text at the top of the page, including a date "12/12/12" and some illegible words.

Handwritten notes and faint text at the bottom of the page, including a date "12/12/12" and some illegible words.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

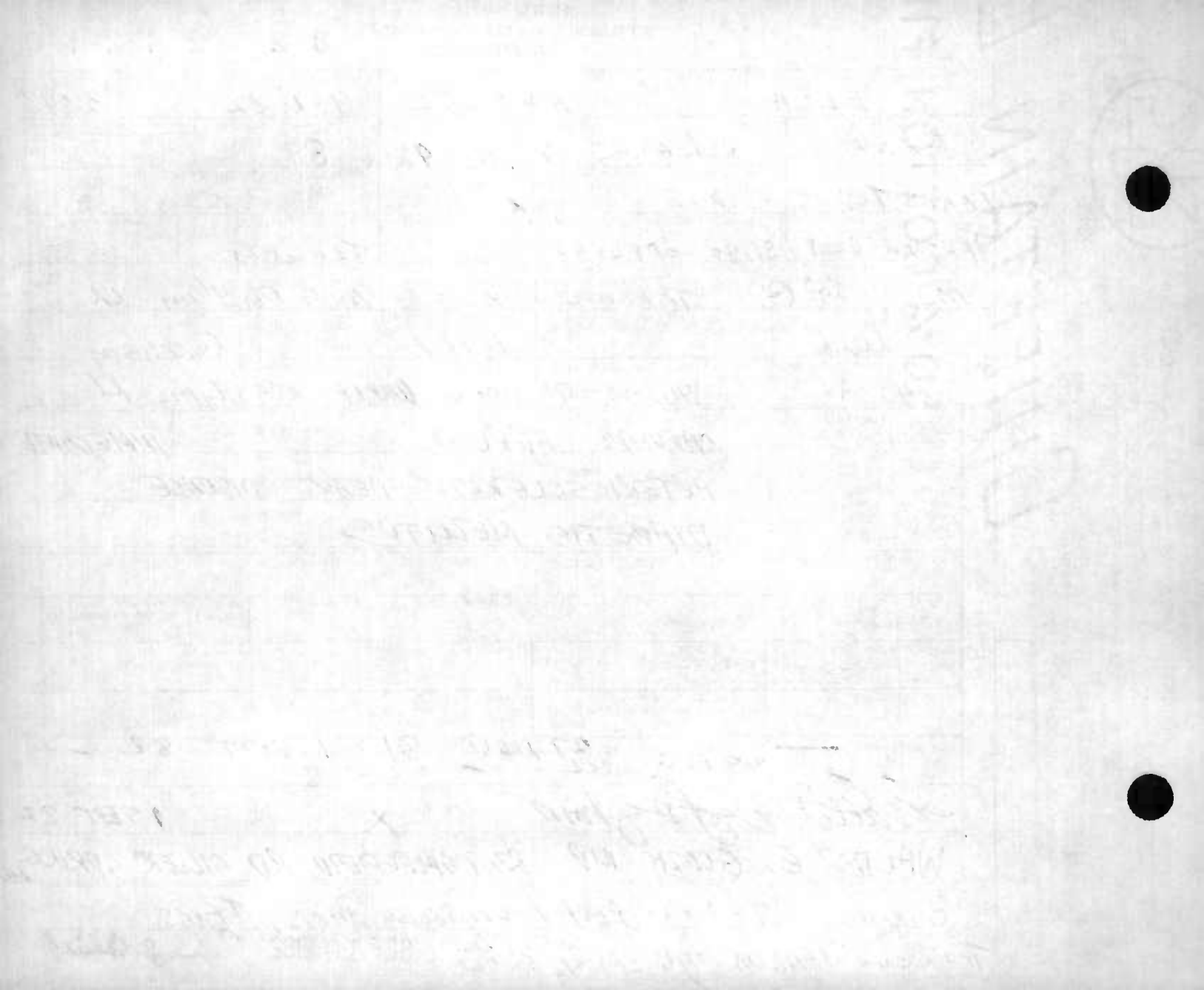
IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, in medical examiner's office, a medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 1 0 REG. NO. | | | | |
|--|--|--|--|---|--|---|--|--------------------------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA RUSSEL | | | | 9-1-82 | | | | 2:54^{PM} |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 6-7-92 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 89 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PARIS, TEXAS | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD. | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SIIGO GARDENS | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Takoma | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unk | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Graham | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES. NO | | | | |
| 16b. SOCIAL SECURITY NO. 462-05-55PL | | 17. INFORMANT MAXINE RAYNE | | ADDRESS 1009 Chillum Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE (c) DIABETIS MELLITUS | | | | | | | APPROXIMATE INTERVAL BETWEEN DEATH AND AUTOPSY IMMEDIATE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) the hospital attended the deceased from 27 NOV 1981 to 1 SEPT 1982 , that (two) lost saw the deceased alive on 28 AUG 1982 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (two) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE DEGREE Walter E. Gooch MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1 SEPT 82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD | | | | 22e. ADDRESS 2309 SHOREFIELD RD SILVER SPRING MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 9-7-82 | | 23c. NAME OF CEMETERY OR CREMATORY REST LAWN GARDEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE PARIS, TEXAS | | |
| 24. FUNERAL DIRECTOR NAME JOHNSON & JENKINS | | | | ADDRESS 716 KENNEDY ST. NW WASH. DC | | 25a. DATE REC'D BY REGISTRAR SEP 10 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Cahill | | | | |

MEDICAL CERTIFICATION

9 9

5000 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 | 2 | 4 | 2 | 1 | 1 |
|---|--------------------|---|---|--|---|--|---|--|--|--|--|--|---|---|---|
| FOR 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ramon Otoniel Ruiz Jr.</i> | | | | | | | | | | 2a DATE KNOWN OF DEATH ESTIMATED <i>Sept 25 1982</i> | | 2b HOUR <i>9:45 AM</i> | | | |
| 3 SEX <i>M</i> | 4 RACE <i>W</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>Nov 23 64</i> | 6 AGE (IN YEARS) LAST BIRTHDAY <i>17 YRS.</i> | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D. C.</i> | 7b CITIZEN OF WHAT COUNTRY? <i>America</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i> | 10 CITY OR TOWN OF DEATH <i>Sil. Spr.</i> | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2231 Luzerne Ave</i> | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Student</i> | 12b KIND OF BUSINESS OR INDUSTRY <i>-----</i> | | | | |
| 13a STATE <i>MD</i> | | | | | | | | | | 13b CITY OR TOWN <i>Mont. Sil. Spr.</i> | | 13c STREET ADDRESS <i>2231 Luzerne Ave</i> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Ramon Otoniel Ruiz Sr.</i> | | | | | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Laura Cotto</i> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | | | | | | | | 16b SOCIAL SECURITY NO. <i>213 94 6556</i> | | 17 INFORMANT (20910) <i>Ramon Otoniel Ruiz Sr. Sil. Spr. Md.</i> | | 17 ADDRESS <i>2231 Luzerne Ave.</i> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>9530</i> IMMEDIATE CAUSE (a) <i>Asphyxiation</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Hanging</i> (c) <i>-----</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i> | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION <i>None</i> | | | | | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>9-25-82</i> | | | | | | | | | | 21b TIME OF INJURY HOUR AM MONTH DAY YEAR <i>P.M. 9-25-82</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Hung self</i> | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE <i>Luzerne Ave. Sil. Spr. Mont. Md.</i> | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE <i>John L. Rogers</i> | | | | | | | | | | TITLE (SPECIFY) <i>MD</i> | | MEDICAL EXAMINER | | DATE SIGNED <i>Sept 25, 1982</i> | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Warner E. Pumphrey INC.</i> | | | | | | | | | | ADDRESS <i>8434 Ga. Ave. Sil. Spr. Md.</i> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | | | | | | | 23b DATE <i>9/27/82</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | 23d LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Mont. Md.</i> | |
| 24 FUNERAL DIRECTOR <i>Warner E. Pumphrey INC.</i> | | | | | | | | | | ADDRESS <i>8434 Ga. Ave. Sil. Spr. Md.</i> | | 25a DATE REC'D. BY REGISTRAR <i>OCT 1 - 1982</i> | | 25b REGISTRAR'S SIGNATURE <i>John J. Conner</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

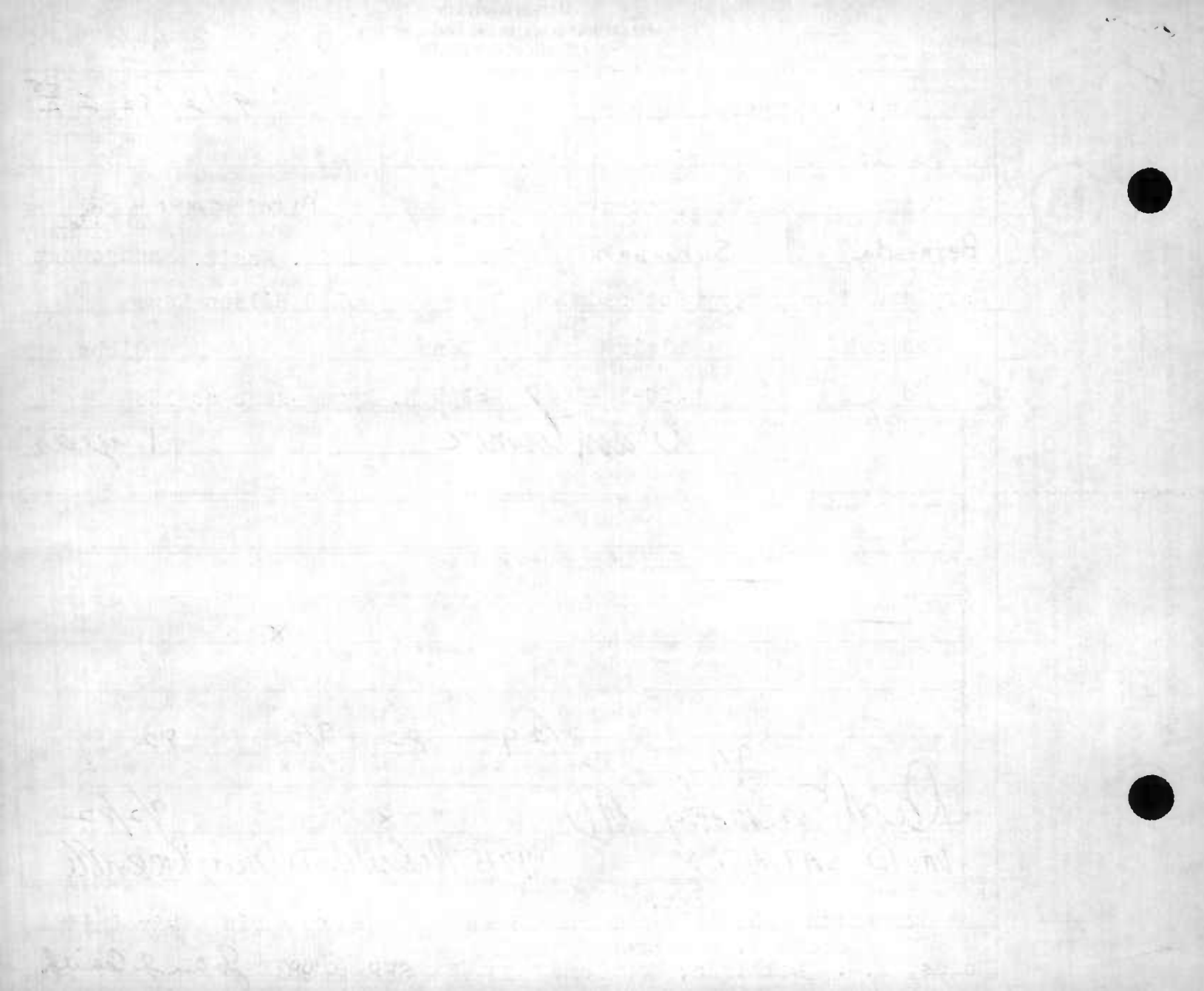
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 1 2 REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (Type or Print) Mary Margaret Blair Ryan | | | | 2a. DATE OF DEATH 9/2/82 2:55 AM | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DA OF BIRTH Sept. 29, 1917 | | 6. AGE 64 YRS. | |
| 7a. BIRTHPLACE (State or Foreign Country) Texas | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Suburban Hospital | | 12a. USUAL OCCUPATION (Type or work for most of working life) Admin. Ass't. | | 12b. KIND OF BUSINESS OR INDUSTRY Highway Management | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Bismark | | 15. MOTHER'S MAIDEN NAME Edna Gibbs | | 16. STREET ADDRESS 6100 Wilson Lane | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) No | | 18b. SOCIAL SECURITY NO. 450-16-2446 | | 17. INFORMANT Ralph W. Ryan | | ADDRESS same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 2396 Brain tumor DUE TO, OR AS A CONSEQUENCE OF (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c): | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I, or Part 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/29 1982 to 9/2 1982 that (I) (we) last saw the deceased alive on 9/1 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE David Satinsky MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/2/82 | |
| 22d. PHYSICIAN'S NAME (Type or Print) DAVID SATINSKY | | | | 22e. ADDRESS 9715 Medical Center Drive, Rockville | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE Sept. 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | |
| 24. FUNERAL DIRECTOR (Name) Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP- 9 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 1 3

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth V. St. Clair | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1982 | | | 2b. HOUR 4:10a M | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 14 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Rigdon | | 13e. STREET ADDRESS 308 Nimitz Avenue 20851 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 42 3627 | | 17. INFORMANT ADDRESS Jean Bort 130 Monroe St. Rockville, Md. 20852 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral Thrombosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15' 18 min 18 min | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Infection + Decubiti</u> | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/10/82</u> to <u>9/13/82</u> , that (I) (we) last saw the deceased alive on <u>8/10/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED 9/13/82 | |
| 22b. SIGNATURE <u>Stephen N. Jones</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. ADDRESS 809 Viers Mill Road Rockville, Md. 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u> | |

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Page 12, 13, 14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 1 4 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE ROLAND SAFFIELD | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 28 1982 | | 2b. HOUR 6:08 a.m. | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 3 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 47 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Dist. Mgr. Rentex Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. CITY OR TOWN MARYLAND BALTIMORE | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 25 CEDAR HILL ROAD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD ROLAND SAFFIELD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE L. GARRETT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 1953-1972 | | 17. INFORMANT ADDRESS MARLENE SAFFIELD, 25 CEDAR HILL ROAD, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) ADENOCARCINOMA COLON DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY, HEPATIC, BONE METASTASES DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE, PNEUMONIA 1 DAY | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 27, 1982 , to SEPTEMBER 28, 1982 , that (I) (we) lost saw the deceased alive on SEPTEMBER 28, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. SEN, LT, MC, USNR | | DEGREE RESIDENT IN MEDICINE ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 28 Sep 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SEN, LT, MC, USNR | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Byrial | | 23b. DATE Oct. 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1982 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the deceased.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 1 5 REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ida Martha SANBORN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 14 82 | | | |
| 3. SEX F | | | | 2b. HOUR 12²⁰ PM | | | |
| 4. RACE CAUCASIAN | | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 20 1892 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 90 | | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Olney | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | | |
| 13c. CITY OR TOWN Takoma Park | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 201 Flower Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas R. Davis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary V. Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 577-18-1512 | | | |
| 17. INFORMANT Ruth Gilhooley, | | | | ADDRESS 10413 Maynard Ct. Damascus, Md. 20872 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) Fracture DUE TO, OR AS A CONSEQUENCE OF Uremia (b) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF Chronic Renal Failure (c) year | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo 2 mo year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/21 1981 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15 1981 to 9/14 1982 , that (I) did last saw the deceased alive on 8/15 1981 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) did not (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | 22c. DATE SIGNED 9/14/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. L. [Signature] | | | | 22e. ADDRESS 1811 P + Philip Dr Olney MD 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Sept. 15, 1982 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Westview | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A. | | | | 25a. DATE RECEIVED BY REGISTRAR SEP 20 1982 | | | |
| ADDRESS Damascus, Md. | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 2 1 6 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN J. SANTORIOS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-14-82 | | | 2b. HOUR 5 P.M. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1898 | | 6 AGE (IN YEARS/LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11911 Hitching Post Lane | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Constantine - Tremoulis | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - Eptakili | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No - | | 16b. SOCIAL SECURITY NO. 215-38-5619 | | 17. INFORMANT Stanley J. Santorios- | | ADDRESS 7104 Old Stage Road Rockville, Maryland | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 10 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. DIABETES - Generalized arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9-3 , 19 82 , to 9-14 , 19 82 , that (I) (we) last saw the deceased alive on 9-14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE William Kurstin MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kurstin | | | | 22e. ADDRESS 1145 19th St. NW WASH. DC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Jos. Gawler's Sons, Inc. 5130 Wisc. Ave., N.W. - Wash., D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

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U.S. GOVERNMENT PRINTING OFFICE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|--------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BLANCHE COE SAYRE | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 17 1982 | | 2b. HOUR 9:54 AM |
| 3. SEX Female | 4. RACE CAUC | 5. DATE OF BIRTH MONTH 12 DAY 25 YEAR 88 | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |
| 13a. STATE MD | | 13b. CITY OR TOWN BETHESDA | | 13c. STREET ADDRESS 6505 GREYSWOOD RD |
| 14. FATHER'S NAME FIRST Myron MIDDLE Coe LAST Coe | | 15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Soper LAST Soper | | 12b. KIND OF BUSINESS OR INDUSTRY home |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 095-28-9497 | | 17. INFORMANT ADDRESS Roberta S. Laux same as 13c |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 35 y. | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 9 16 1982 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 P.M. 9 16 1982 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ARRESTED IN BED | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET 6505 GREYSWOOD CITY OR TOWN BETHESDA COUNTY MONT. STATE MD | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Francis C. Mayne | | TITLE (SPECIFY) Dept | | DATE SIGNED 9/17/82 |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayne | | ADDRESS Emm Wisconsin Ave BETHESDA MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/20/82 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN Elmira COUNTY New York STATE New York |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler, Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel |
| 1331 Rockville Pike Rockville, Md. 20852 | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 1 8 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN F SCAFIDE | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 24 82 | | 2b. HOUR M 410 P | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Richmond, Va. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Western Union | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN College Park | | 13e. STREET ADDRESS 5002-Laguna Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert J. Sauer, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine G. Gouldman | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 578-24-0907 | | | | 17. INFORMANT Benedict F. Scafide (Husband) Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) DISSEMINATED CARCINOMATOSIS | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS. |
| DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF THE COLON | | | | | | | 5 YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF THE OVARY | | | | | | | 8 3/10 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NONE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/23 19 82 , to 9/24 19 82 , that (1) (we) last saw the deceased alive on 9/23 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE S. RALPH Himmelfarb | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. RALPH Himmelfarb | | | | 22e. ADDRESS 11570 OLD GEORGETOWN RD BETHESDA, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-25-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 takes on any injury, or other traumatic event, the medical examiner may be notified at any time.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 1 9 REG. NO. | | | |
|--|--|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>HILDA B. SCHMIDTMAN</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 20 82</i> | | | | 2b. HOUR <i>8:45 A</i> | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR <i>JAN. 10, 1896</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | | 12b. KIND OF BUSINESS OR INDUSTRY BUSINESS | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALT. COUNTY | | | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4307-MARBLE HALL ROAD | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY SCHMIDTMAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA BECKER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-28-9113A | | 17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD- NLH-ROCKVILLE, MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 yrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> , 19 <i>28</i> , to <i>Sept. 20</i> , 19 <i>82</i> that (I) (we) last saw the deceased alive on <i>Sept. 19</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Harold F. McCann M.D.</i> | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-20-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN | | | | | | 22e. ADDRESS 3355-16th St. N.W. WASH. D.C. 20040 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY -LOUDON PARK CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HYSONG COMPANY, INC. | | | | | | ADDRESS -1300- N ST., NW WASH., DC | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Coniff</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified about.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 2 0 REG. NO. | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|---|-------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB H. SCHROEDER | | | | | | | | | | SEPTEMBER 12, 1982 | | | | 8:15 PM | | | |
| 3. SEX MALE | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH MONTH DAY YEAR DEC 29, 1908 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 RS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) KANSAS | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NAVAL ORD | | | 12b. KIND OF BUSINESS OR INDUSTRY LAB. | | | | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY SILVER SPRING | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 10421 HAYES AVENUE | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY SCHROEDER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA SCHMIDT | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 512-05-6920 | | | 17. INFORMANT VIRGINIA A. SCHROEDER | | | ADDRESS SAME AS 13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2396 Cardio-Pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Undermined " " | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sep 13, 1982, to Sep 13, 1982, that (I) (we) lost saw the deceased alive on Sep 13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Octavio Polanco, Jr. | | | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/13/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) OCTAVIO POLANCO | | | | | | 22e. ADDRESS 5530 Wisconsin ave - | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/15/82 | | | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | | | | | | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | | | |

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Handwritten notes and scribbles covering the page, including the words "OCT 1910" and "Palm Springs" visible in the lower right quadrant.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 82 24221 | |
|--|--|--|--|---|--|--|--|---|---|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE A. SEIDLE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 82 | | 2b. HOUR 12:50 AM | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 16, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY STOREROOM | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE | | | | | | 13b. COUNTY NEW CASTLE | | 13c. CITY OR TOWN WILMINGTON | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY WITT | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE SCHANBLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 221-18-6664 | | 17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD - NLH - ROCKVILLE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4860 IMMEDIATE CAUSE (a) <i>Thrombosis due to Septic Arteries</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 5, 19 78 , to SEPT. 10, 19 82 , that (I) (we) last saw the deceased alive on SEPT. 10, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Dr. Thomas Dooley</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED SEPT. 10, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THOMAS DOOLEY | | | | 22e. ADDRESS 2901- OLNEY - SANDY SPRING RD., OLNEY, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY GRACE LAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE NEW CASTLE CO. DELAWARE | | | | | |
| 24. FUNERAL DIRECTOR NAME HYSONG COMPANY, INC. | | | | ADDRESS 1300-N ST., NW WASH., DC | | 25. SEP 21 1982 | | | | | |



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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE ASSISTANT SECRETARY
FOR AGRICULTURAL MARKETING
DIVISION OF MARKET ECONOMICS
WASHINGTON, D.C.
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WASHINGTON, D.C.
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OFFICE OF THE ASSISTANT SECRETARY
FOR AGRICULTURAL MARKETING
DIVISION OF MARKET ECONOMICS
WASHINGTON, D.C.
20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 2 2 | | | | |
|---|--|--|--|---|--|--|---|--|--|--|--------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Eliot R. Selinger | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 1, 1982 | | | | | 2b. HOUR 6:50 AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1917 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7106 Meadow Lane | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manufacture Rep. | | | 12b. KIND OF BUSINESS OR INDUSTRY Wholesale | | | | |
| 13a. STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Chevy Chase | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7106 Meadow Lane | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Monroe M. Selinger | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Roth | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Mark M. Selinger | | | ADDRESS 1616 18th St. N.W. Wash. DC | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma of the Brain 1919 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Mo. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 82 to Sept. 1 19 82 , that (I) (we) last saw the deceased alive on Aug. 30 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Warren D. Brill, M.D. | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 1982 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Warren D. Brill, M.D. | | | | | | | | 22e. ADDRESS 2000 N. St. N.W. Wash., D.C. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Mem. PK. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wash., D.C. | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1982 | | | | | 25b. REGISTRAR'S SIGNATURE John J. Gawler | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 2 3

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES WILLIAM SHAFFER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 27, 1982 | | 2b. HOUR ^p 1:30 ^M | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 31, 1947 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 35 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wreman | | 12b. KIND OF BUSINESS OR INDUSTRY Utility | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY Calvert | | 13c. CITY OR TOWN PRINCE FREDERICK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6025 DAWN DRIVE (20678) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William E Shaffer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S Morrison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 214-48-7935 | | 17. INFORMANT ADDRESS MRS. BONNIE SHAFFER (WIFE) SAME AS ABOVE | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:2000 IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 Min.Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.DUE TO, OR AS A CONSEQUENCE OF
(b) **DIFFUSE HISTIOCYTIC LYMPHOMA**
DUE TO, OR AS A CONSEQUENCE OF
(c)**10 Mo.**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that this hospital attended the deceased from AUGUST 9, 1982 , to SEPTEMBER 27, 1982 , that (we) lost saw the deceased alive on SEPTEMBER 27, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (th) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard A. Sorace | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. SORACE | | | | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Southern Mem Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk Calvert Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raboch Funeral Home Owings MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Carter | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| DATE | DESCRIPTION | AMOUNT |
|---------|-------------|--------|
| 1/10/64 | ... | ... |
| 1/11/64 | ... | ... |
| 1/12/64 | ... | ... |
| 1/13/64 | ... | ... |
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| 1/17/64 | ... | ... |
| 1/18/64 | ... | ... |
| 1/19/64 | ... | ... |
| 1/20/64 | ... | ... |
| 1/21/64 | ... | ... |
| 1/22/64 | ... | ... |
| 1/23/64 | ... | ... |
| 1/24/64 | ... | ... |
| 1/25/64 | ... | ... |
| 1/26/64 | ... | ... |
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| 1/28/64 | ... | ... |
| 1/29/64 | ... | ... |
| 1/30/64 | ... | ... |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case of a medicolegal death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 2 4 REG. NO. | | | |
|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thaddeus L Sharkey | | | | 2b. HOUR 9:35p M.L. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 5 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer Consultant Engineering | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3503 Raymond Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Sharkey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Talcott | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | | |
| 16b. SOCIAL SECURITY NO. 577-05-3289 | | 17. INFORMANT NAME ADDRESS Annabelle H. Sharkey Same as item #. 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic cardiovascular disease 30 years | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (he) (she) (it) attended the deceased from 9/15 , 19 77 , to 9/18 , 19 82 , that (he) (she) (it) saw the deceased alive on 9/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Samuel D. Goldberg | | | | 22c. DATE SIGNED 9/15/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel D. Goldberg | |
| 22e. ADDRESS 11125 Rockville Pk Road Rockville, Md | | | | 22f. DATE REC'D. BY REGISTRAR SEP 21 1982 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. | | | | 25. REGISTRAR'S SIGNATURE John J. Canfield | | | |

2100 loc. av. N.W. Wash., D.C.
Lester Lamm's Sons, Inc.

9/18/52
Bristol
Arkham Cemetery
Indianapolis, Mo.

Robert L. Lamm

*Enclosed is a copy of the
testimony of the witness in the
case of the State vs. [illegible]*

9/18/52-1589

James
Shirley
by
Tolson

Grey House
Washington

3302 Raymond Street

Architectural Commission Indianapolis

file

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 4 | 2 | 2 | 5 | | | |
|---|--|--|---|--|--|---|--|--|--|---|---|-----------------------------------|---|-----|------------------------|-------|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ROBERT PAUL SHARPE | | | | | | | | | | SEPT | | 5 | | 82 | | 4:24A | | M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | |
| M | | | W | | | May 12 1914 XOX | | | 68 | | | YRS. | | | MONTHS DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| MISSOURI | | | U.S.A. | | | | | | MONTGOMERY MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| SILVER SPRING | | | 9322 OCALA ST. | | | | | | ELECTRICIAN | | | IBEW | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | | | | | |
| 13a. STATE | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9322 OCALA ST. | | | | | | | |
| 13a. COUNTY | | | | | | | | | | | | | | | | | | | |
| 13a. CITY OR TOWN | | | | | | | | | | SILVER SPRING | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| ROBERT LEE SHARPE | | | | | NORAH HUBBARD | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | |
| NO | | | | | 217-32-2187 | | | | | DAUGHTER ADDRESS 815 ENGLEWOOD ELEANOR SIGAFOOSE LANSING, KANSAS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction of coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 12 hours | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-4, 19 81, to 9-5, 19 82, that (I) (we) lost saw the deceased alive on 8-19, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | | 9/7/82 | | | | | | | |
| 22b. SIGNATURE Frederick G. Barr | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22d. SIGNATURE Frederick G. Barr | | | | | 22e. ADDRESS 5509 HOOVER ST. BETHESDA, MARYLAND | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| BURIAL | | | 9/8/82 | | | GATE OF HEAVEN | | | SILVER SPRING MONT MD. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | SEP 10 1982 | | | | | Joan J. Conner | | | | | | | | | |

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SILVER SPRING

3322 CALA ST.

MONTGOMERY SILVER SPRING

NO

MISSOURI

MONTGOMERY

SHARPE

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ROBERT

217-32-2187

NO



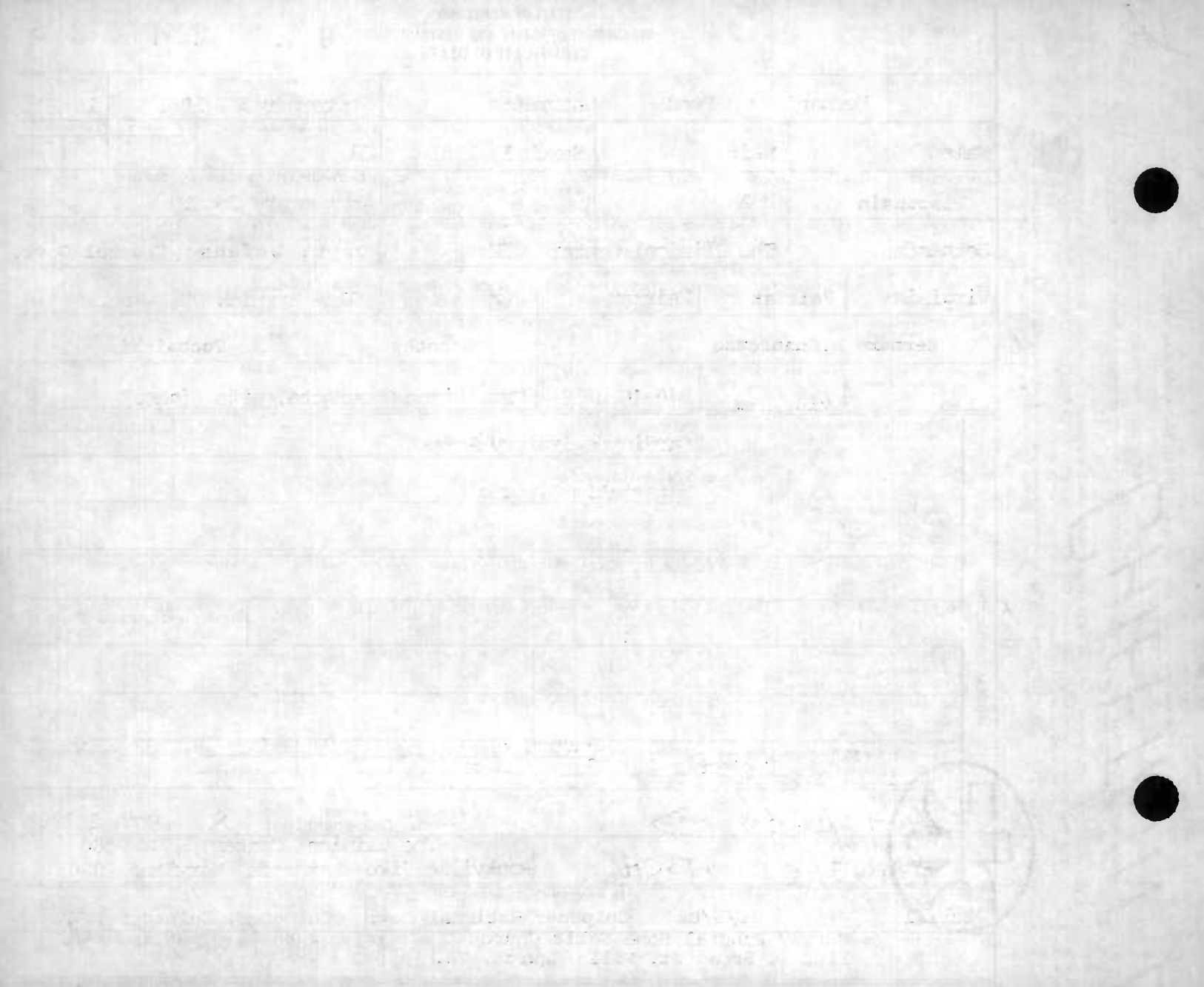
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 2 6 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Bernard Fred Shaurette | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 30, 1982 | | 2b. HOUR 10:50 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 1, 1951 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. Defense | | 12b. KIND OF BUSINESS OR INDUSTRY Federal Govt. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia 13c. COUNTY Fairfax 13d. CITY OR TOWN Fairfax | | | | 13e. STREET ADDRESS 9136 Barrick St., Apt. 3 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard N. Shaurette | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Tuchalski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 040-46-0518 | | 17. INFORMANT ADDRESS Mrs. Diane Shaurette, wife (same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1719 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 25, 1982 , to September 30, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 30, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Harvey L. Deutsch</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Oct. 1, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY L. DEUTSCH | | | | 22e. ADDRESS The Clinical Center, NIH, 9000 Rockville Pike, Bethesda, Maryland 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY Culpeper National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper, Culpeper, VA | |
| 24. FUNERAL DIRECTOR NAME Murphy Funeral Home Falls Church 1102 W. Broad St. Falls Church, VA. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1982 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified.

FOR
 1 - STATE
 REGISTRAR

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 2 2 4 2 2 7
 REG. NO.

| | | | | | | |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM Kelly SHEETS | | | 2a. DATE OF DEATH MONTH DAY YEAR September 2, 1982 | | 2b. HOUR 9:07 PM | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR April 30, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | 12a. USUAL OCCUPATION (IF NOT OF WORKING LIFE) Carpenter | | 12b. OF BUSINESS OR INDUSTRY Self Employed |
| 13a. STATE Md. 20706 | 13b. COUNTY Prince Geo. | 13c. CITY OR TOWN Seabrook | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 9512 Franklin Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Sheets | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Florida Akers | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 228 14 2039 | | 17. INFORMANT ADDRESS Ruby L. Sheets Same as #13 (Wife) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | |
| 19a. DATE OF OPERATION 9/2/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABOVE | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 to 9/2/82 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Thomas Y. Ko, M.D. | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/3/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Y. Ko, M.D. | | 22e. ADDRESS 9131 Piscataway Rd. Clinton, Md. 20735 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY Brentwood P.G. Maryland |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 REGISTRAR'S SIGNATURE John J. Smith | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 2 2 8 | |
|---|----------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ricca Shelley | | |
| 2a. DATE OF DEATH MONTH DAY YEAR 9/25/82 | | 2b. HOUR 6:12p.m. | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sep. 6, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher (Ret) | |
| 12b. KIND OF BUSINESS OR INDUSTRY School | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE New York 13c. CITY OR TOWN unknown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 310 West 86th Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Moses Brody | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nadia Brick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 098-32-8610 | | 17. INFORMANT ADDRESS Mrs. Leonora | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural Effusion 1940 | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma (c) Renal Carcinoma | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982, to 9-25-82, that (I/we) last saw the deceased alive on 9-25-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert Kramer M.D. | | DEGREE | | 22c. DATE SIGNED 9/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER, M.D. | | 22e. ADDRESS 8630 PENTON BL. S.E. S.W. DC. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md. | | 23e. DATE REC'D BY REGISTRAR 10/1/82 | | | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

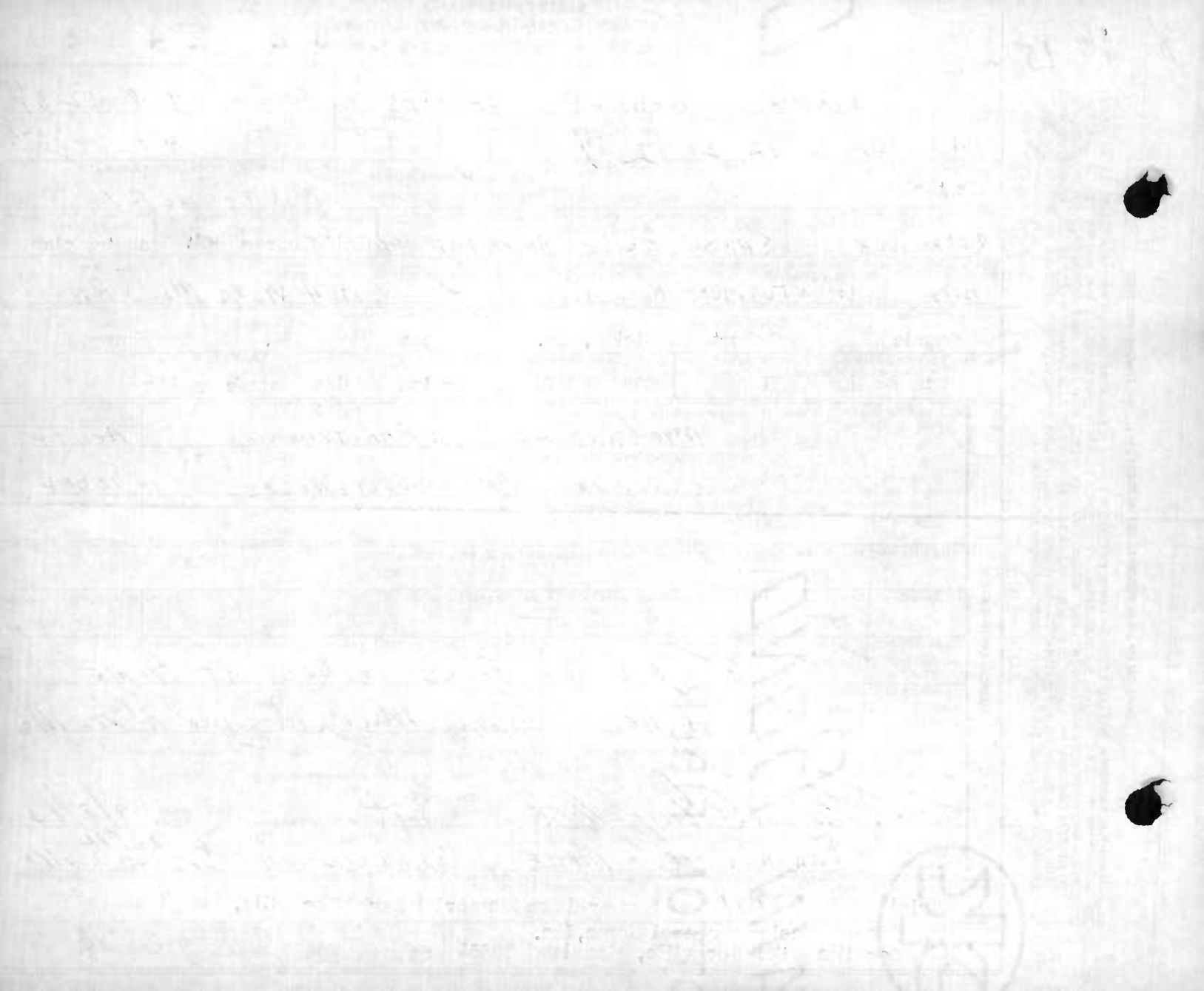
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-----------------|--|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) LONNIE Robert SHIELDS | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9 8 1982 6 48 PM | | | 2b. HOUR | | |
| 3. SEX Male | 4. RACE CAUC | 5. DATE OF BIRTH MONTH DAY YEAR 12 20 1969 | 6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9 8 1982 6 48 PM | 2d. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GRAVE ADVENTIST HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Golf Course Supt. | | 12b. KIND OF BUSINESS OR INDUSTRY country club |
| 13a. STATE MD | | | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN Rockville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 20851 1704 VIER'S MILL RD | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lonnie Robert Shields, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena M. Sherron | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | (IF YES, GIVE WAR OR DATES) WWII | | 16b. SOCIAL SECURITY NO. 274 03 2706 | | 17. INFORMANT Bernice Shields same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF. | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 P.M. 9 8 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) FOUND IN BED AT HOME | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1704 Viers Mill Rd Rockville MONT. MD | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle | | | TITLE (SPECIFY) DPT M.D. | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | DATE SIGNED 9/8/82 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20851 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | | |

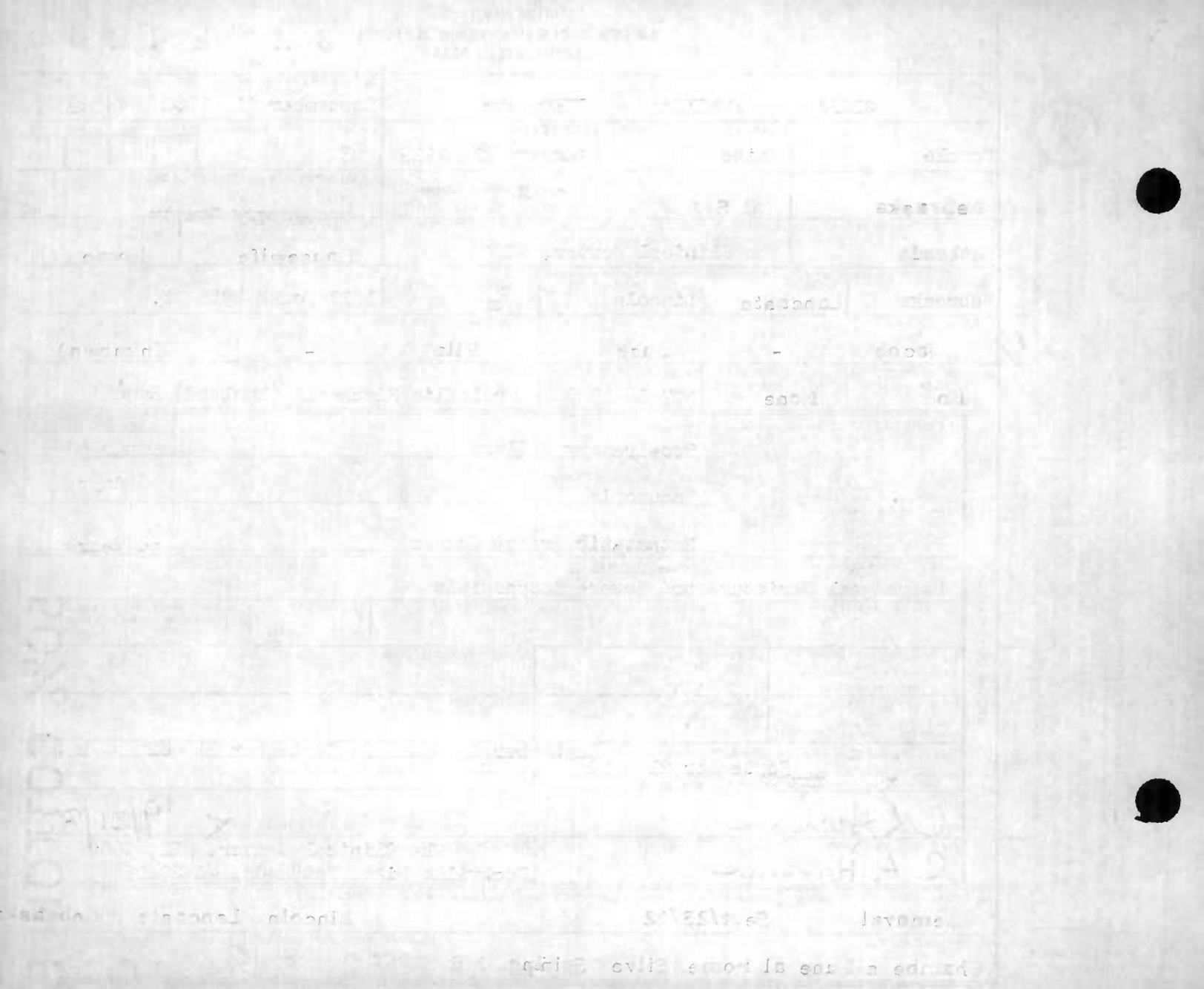


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 3 0 REG. NO. | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARA EVELINA SIECKMANN | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1982 | | | | 2b. HOUR 5:35 PM | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR January 31, 1919 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska | | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Nebraska | | | 13b. CITY OR TOWN Lancaster | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS 1811 South 49th St. | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob - Buss | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella - (Unknown) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 507-18-5305 | | | 17. INFORMANT ADDRESS Mr Leslie Sieckmann (husband) Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Breast Cancer</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 17 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Esophageal Stricture and Severe Esophagitis</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 1</u> , 19 <u>82</u> , to <u>September 21</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 21</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE C A Harman | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 9/21/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C A Harman | | | 22e. ADDRESS The Clinical Center, NIH, 9000 Rockville Pike, Bethesda, Md 20205 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE Sept/23/82 | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lincoln, Lancaster, Nebraska | | | | | | |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home | | | ADDRESS Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Givish | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 7 2 2 4 2 3 1 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia L. Silvestro | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 5 82 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 25, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | 2b. HOUR 11:45 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTH. HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. GOVT. | | 12b. KIND OF BUSINESS OR INDUSTRY INSPECTOR | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA | | | | | | 13b. CITY OR TOWN ARLINGTON | | 13c. STREET ADDRESS 1324- S. 28th STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACOB - BATTINGER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET SPAHN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 091-14-7192 | | 17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD - NLH - EXECUTIVE DIR. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) <u>REICHARD</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not see the body after death. June 14, 1974, to Sept. 5, 1982, that (I) (we) lost saw the deceased alive on Sept. 5, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE <u>DE. THOMAS DOOLEY</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 5, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DE. THOMAS DOOLEY | | | | 22e. ADDRESS 2901-OLNEY-SANDY SPRING RD., OLNEY, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME HYSO NG FUNERAL HOME - 1300- N ST., NW WASH., DC | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 3 2 | | | |
|---|--|---|--|--|---|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth Larew Slayton | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 10 82 | | | | | 2b. HOUR 3:54 PM | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7b. IF UNDER 24 HRS. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 9. CITIZEN OF WHAT COUNTRY? United States | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Edward Larew | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Miller | | | | | 16. STREET ADDRESS 303 Adclare Road (20850) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. Not Available | | 17. INFORMANT ADDRESS Clarence H. Slayton, Jr. 4307 Millwood Road Mt. Airy, Md 21771 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) NEPHROSIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months YEARS | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WITNESS <input type="checkbox"/> NOT WITNESS <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10/82 to 9/10/82 that (I) (we) last saw the deceased alive on 9/10/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | 22b. DATE SIGNED 9/10/82 | | | |
| 22c. SIGNATURE THOS G. WARD MD | | | | | 22d. ADDRESS 6116 RABINWOOD, Bethesda, Md 20817 | | | | | 22e. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | | 23b. DATE Sept. 10, 1982 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY ADDRESS P.A., ROCKVILLE, MARYLAND | | | | | 25. DATE REC'D. BY REGISTRAR SEP 15 1982 | | | | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] | | | |

BP

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 2 2 4 2 3 3 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MILLARD F. SMITH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 6, 1982 | | | 2b. HOUR 12¹⁰ PM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 2 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Landscaping | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bert | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Green | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 230 10 1946 | | 17. INFORMANT Emmanuel Smith | | ADDRESS 506 Broadwood Dr. Rockville Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) COAL WORKER'S PNEUMOCONIOSIS ; COR PULMONALE RENAL FAILURE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6 , 19 82 , to 9/6 , 19 82 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 9/5 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not witness the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Carl I. Schoenberger MD | | | | | DEGREE MD | | | 22c. DATE SIGNED 9-6-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberger MD | | | | | 22e. ADDRESS 4701 Randolph Rd Rockville MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Fee Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lee County Rose Hill, Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | |
| 1331 Rockville Pike Rockville, Maryland 20852 | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME TO EXECUTE THE CERTIFICATE. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. GIVE PAGES 7, 8, AND 9 TO THE FUNERAL HOME. GIVE PAGES 10, 11, AND 12 TO THE MEDICAL EXAMINER. GIVE PAGES 13, 14, AND 15 TO THE FUNERAL HOME. GIVE PAGES 16, 17, AND 18 TO THE MEDICAL EXAMINER. GIVE PAGES 19, 20, AND 21 TO THE FUNERAL HOME. GIVE PAGES 22, 23, AND 24 TO THE MEDICAL EXAMINER. GIVE PAGES 25, 26, AND 27 TO THE FUNERAL HOME. GIVE PAGES 28, 29, AND 30 TO THE MEDICAL EXAMINER. GIVE PAGES 31, 32, AND 33 TO THE FUNERAL HOME. GIVE PAGES 34, 35, AND 36 TO THE MEDICAL EXAMINER. GIVE PAGES 37, 38, AND 39 TO THE FUNERAL HOME. GIVE PAGES 40, 41, AND 42 TO THE MEDICAL EXAMINER. GIVE PAGES 43, 44, AND 45 TO THE FUNERAL HOME. GIVE PAGES 46, 47, AND 48 TO THE MEDICAL EXAMINER. GIVE PAGES 49, 50, AND 51 TO THE FUNERAL HOME. GIVE PAGES 52, 53, AND 54 TO THE MEDICAL EXAMINER. GIVE PAGES 55, 56, AND 57 TO THE FUNERAL HOME. GIVE PAGES 58, 59, AND 60 TO THE MEDICAL EXAMINER. GIVE PAGES 61, 62, AND 63 TO THE FUNERAL HOME. GIVE PAGES 64, 65, AND 66 TO THE MEDICAL EXAMINER. GIVE PAGES 67, 68, AND 69 TO THE FUNERAL HOME. GIVE PAGES 70, 71, AND 72 TO THE MEDICAL EXAMINER. GIVE PAGES 73, 74, AND 75 TO THE FUNERAL HOME. GIVE PAGES 76, 77, AND 78 TO THE MEDICAL EXAMINER. GIVE PAGES 79, 80, AND 81 TO THE FUNERAL HOME. GIVE PAGES 82, 83, AND 84 TO THE MEDICAL EXAMINER. GIVE PAGES 85, 86, AND 87 TO THE FUNERAL HOME. GIVE PAGES 88, 89, AND 90 TO THE MEDICAL EXAMINER. GIVE PAGES 91, 92, AND 93 TO THE FUNERAL HOME. GIVE PAGES 94, 95, AND 96 TO THE MEDICAL EXAMINER. GIVE PAGES 97, 98, AND 99 TO THE FUNERAL HOME. GIVE PAGES 100, 101, AND 102 TO THE MEDICAL EXAMINER. GIVE PAGES 103, 104, AND 105 TO THE FUNERAL HOME. GIVE PAGES 106, 107, AND 108 TO THE MEDICAL EXAMINER. GIVE PAGES 109, 110, AND 111 TO THE FUNERAL HOME. GIVE PAGES 112, 113, AND 114 TO THE MEDICAL EXAMINER. GIVE PAGES 115, 116, AND 117 TO THE FUNERAL HOME. GIVE PAGES 118, 119, AND 120 TO THE MEDICAL EXAMINER. GIVE PAGES 121, 122, AND 123 TO THE FUNERAL HOME. GIVE PAGES 124, 125, AND 126 TO THE MEDICAL EXAMINER. GIVE PAGES 127, 128, AND 129 TO THE FUNERAL HOME. GIVE PAGES 130, 131, AND 132 TO THE MEDICAL EXAMINER. GIVE PAGES 133, 134, AND 135 TO THE FUNERAL HOME. GIVE PAGES 136, 137, AND 138 TO THE MEDICAL EXAMINER. GIVE PAGES 139, 140, AND 141 TO THE FUNERAL HOME. GIVE PAGES 142, 143, AND 144 TO THE MEDICAL EXAMINER. GIVE PAGES 145, 146, AND 147 TO THE FUNERAL HOME. GIVE PAGES 148, 149, AND 150 TO THE MEDICAL EXAMINER. GIVE PAGES 151, 152, AND 153 TO THE FUNERAL HOME. GIVE PAGES 154, 155, AND 156 TO THE MEDICAL EXAMINER. GIVE PAGES 157, 158, AND 159 TO THE FUNERAL HOME. GIVE PAGES 160, 161, AND 162 TO THE MEDICAL EXAMINER. GIVE PAGES 163, 164, AND 165 TO THE FUNERAL HOME. GIVE PAGES 166, 167, AND 168 TO THE MEDICAL EXAMINER. GIVE PAGES 169, 170, AND 171 TO THE FUNERAL HOME. GIVE PAGES 172, 173, AND 174 TO THE MEDICAL EXAMINER. GIVE PAGES 175, 176, AND 177 TO THE FUNERAL HOME. GIVE PAGES 178, 179, AND 180 TO THE MEDICAL EXAMINER. GIVE PAGES 181, 182, AND 183 TO THE FUNERAL HOME. GIVE PAGES 184, 185, AND 186 TO THE MEDICAL EXAMINER. GIVE PAGES 187, 188, AND 189 TO THE FUNERAL HOME. GIVE PAGES 190, 191, AND 192 TO THE MEDICAL EXAMINER. GIVE PAGES 193, 194, AND 195 TO THE FUNERAL HOME. GIVE PAGES 196, 197, AND 198 TO THE MEDICAL EXAMINER. GIVE PAGES 199, 200, AND 201 TO THE FUNERAL HOME. GIVE PAGES 202, 203, AND 204 TO THE MEDICAL EXAMINER. GIVE PAGES 205, 206, AND 207 TO THE FUNERAL HOME. GIVE PAGES 208, 209, AND 210 TO THE MEDICAL EXAMINER. GIVE PAGES 211, 212, AND 213 TO THE FUNERAL HOME. GIVE PAGES 214, 215, AND 216 TO THE MEDICAL EXAMINER. GIVE PAGES 217, 218, AND 219 TO THE FUNERAL HOME. GIVE PAGES 220, 221, AND 222 TO THE MEDICAL EXAMINER. GIVE PAGES 223, 224, AND 225 TO THE FUNERAL HOME. GIVE PAGES 226, 227, AND 228 TO THE MEDICAL EXAMINER. GIVE PAGES 229, 230, AND 231 TO THE FUNERAL HOME. GIVE PAGES 232, 233, AND 234 TO THE MEDICAL EXAMINER. GIVE PAGES 235, 236, AND 237 TO THE FUNERAL HOME. GIVE PAGES 238, 239, AND 240 TO THE MEDICAL EXAMINER. GIVE PAGES 241, 242, AND 243 TO THE FUNERAL HOME. GIVE PAGES 244, 245, AND 246 TO THE MEDICAL EXAMINER. GIVE PAGES 247, 248, AND 249 TO THE FUNERAL HOME. GIVE PAGES 250, 251, AND 252 TO THE MEDICAL EXAMINER. GIVE PAGES 253, 254, AND 255 TO THE FUNERAL HOME. GIVE PAGES 256, 257, AND 258 TO THE MEDICAL EXAMINER. GIVE PAGES 259, 260, AND 261 TO THE FUNERAL HOME. GIVE PAGES 262, 263, AND 264 TO THE MEDICAL EXAMINER. GIVE PAGES 265, 266, AND 267 TO THE FUNERAL HOME. GIVE PAGES 268, 269, AND 270 TO THE MEDICAL EXAMINER. GIVE PAGES 271, 272, AND 273 TO THE FUNERAL HOME. GIVE PAGES 274, 275, AND 276 TO THE MEDICAL EXAMINER. GIVE PAGES 277, 278, AND 279 TO THE FUNERAL HOME. GIVE PAGES 280, 281, AND 282 TO THE MEDICAL EXAMINER. GIVE PAGES 283, 284, AND 285 TO THE FUNERAL HOME. GIVE PAGES 286, 287, AND 288 TO THE MEDICAL EXAMINER. GIVE PAGES 289, 290, AND 291 TO THE FUNERAL HOME. GIVE PAGES 292, 293, AND 294 TO THE MEDICAL EXAMINER. GIVE PAGES 295, 296, AND 297 TO THE FUNERAL HOME. GIVE PAGES 298, 299, AND 300 TO THE MEDICAL EXAMINER. GIVE PAGES 301, 302, AND 303 TO THE FUNERAL HOME. GIVE PAGES 304, 305, AND 306 TO THE MEDICAL EXAMINER. GIVE PAGES 307, 308, AND 309 TO THE FUNERAL HOME. GIVE PAGES 310, 311, AND 312 TO THE MEDICAL EXAMINER. GIVE PAGES 313, 314, AND 315 TO THE FUNERAL HOME. GIVE PAGES 316, 317, AND 318 TO THE MEDICAL EXAMINER. GIVE PAGES 319, 320, AND 321 TO THE FUNERAL HOME. GIVE PAGES 322, 323, AND 324 TO THE MEDICAL EXAMINER. GIVE PAGES 325, 326, AND 327 TO THE FUNERAL HOME. GIVE PAGES 328, 329, AND 330 TO THE MEDICAL EXAMINER. GIVE PAGES 331, 332, AND 333 TO THE FUNERAL HOME. GIVE PAGES 334, 335, AND 336 TO THE MEDICAL EXAMINER. GIVE PAGES 337, 338, AND 339 TO THE FUNERAL HOME. GIVE PAGES 340, 341, AND 342 TO THE MEDICAL EXAMINER. GIVE PAGES 343, 344, AND 345 TO THE FUNERAL HOME. GIVE PAGES 346, 347, AND 348 TO THE MEDICAL EXAMINER. GIVE PAGES 349, 350, AND 351 TO THE FUNERAL HOME. GIVE PAGES 352, 353, AND 354 TO THE MEDICAL EXAMINER. GIVE PAGES 355, 356, AND 357 TO THE FUNERAL HOME. GIVE PAGES 358, 359, AND 360 TO THE MEDICAL EXAMINER. GIVE PAGES 361, 362, AND 363 TO THE FUNERAL HOME. GIVE PAGES 364, 365, AND 366 TO THE MEDICAL EXAMINER. GIVE PAGES 367, 368, AND 369 TO THE FUNERAL HOME. GIVE PAGES 370, 371, AND 372 TO THE MEDICAL EXAMINER. GIVE PAGES 373, 374, AND 375 TO THE FUNERAL HOME. GIVE PAGES 376, 377, AND 378 TO THE MEDICAL EXAMINER. GIVE PAGES 379, 380, AND 381 TO THE FUNERAL HOME. GIVE PAGES 382, 383, AND 384 TO THE MEDICAL EXAMINER. GIVE PAGES 385, 386, AND 387 TO THE FUNERAL HOME. GIVE PAGES 388, 389, AND 390 TO THE MEDICAL EXAMINER. GIVE PAGES 391, 392, AND 393 TO THE FUNERAL HOME. GIVE PAGES 394, 395, AND 396 TO THE MEDICAL EXAMINER. GIVE PAGES 397, 398, AND 399 TO THE FUNERAL HOME. GIVE PAGES 400, 401, AND 402 TO THE MEDICAL EXAMINER. GIVE PAGES 403, 404, AND 405 TO THE FUNERAL HOME. GIVE PAGES 406, 407, AND 408 TO THE MEDICAL EXAMINER. GIVE PAGES 409, 410, AND 411 TO THE FUNERAL HOME. GIVE PAGES 412, 413, AND 414 TO THE MEDICAL EXAMINER. GIVE PAGES 415, 416, AND 417 TO THE FUNERAL HOME. GIVE PAGES 418, 419, AND 420 TO THE MEDICAL EXAMINER. GIVE PAGES 421, 422, AND 423 TO THE FUNERAL HOME. GIVE PAGES 424, 425, AND 426 TO THE MEDICAL EXAMINER. GIVE PAGES 427, 428, AND 429 TO THE FUNERAL HOME. GIVE PAGES 430, 431, AND 432 TO THE MEDICAL EXAMINER. GIVE PAGES 433, 434, AND 435 TO THE FUNERAL HOME. GIVE PAGES 436, 437, AND 438 TO THE MEDICAL EXAMINER. GIVE PAGES 439, 440, AND 441 TO THE FUNERAL HOME. GIVE PAGES 442, 443, AND 444 TO THE MEDICAL EXAMINER. GIVE PAGES 445, 446, AND 447 TO THE FUNERAL HOME. GIVE PAGES 448, 449, AND 450 TO THE MEDICAL EXAMINER. GIVE PAGES 451, 452, AND 453 TO THE FUNERAL HOME. GIVE PAGES 454, 455, AND 456 TO THE MEDICAL EXAMINER. GIVE PAGES 457, 458, AND 459 TO THE FUNERAL HOME. GIVE PAGES 460, 461, AND 462 TO THE MEDICAL EXAMINER. GIVE PAGES 463, 464, AND 465 TO THE FUNERAL HOME. GIVE PAGES 466, 467, AND 468 TO THE MED

1- FOR
STATE
REGISTRAR

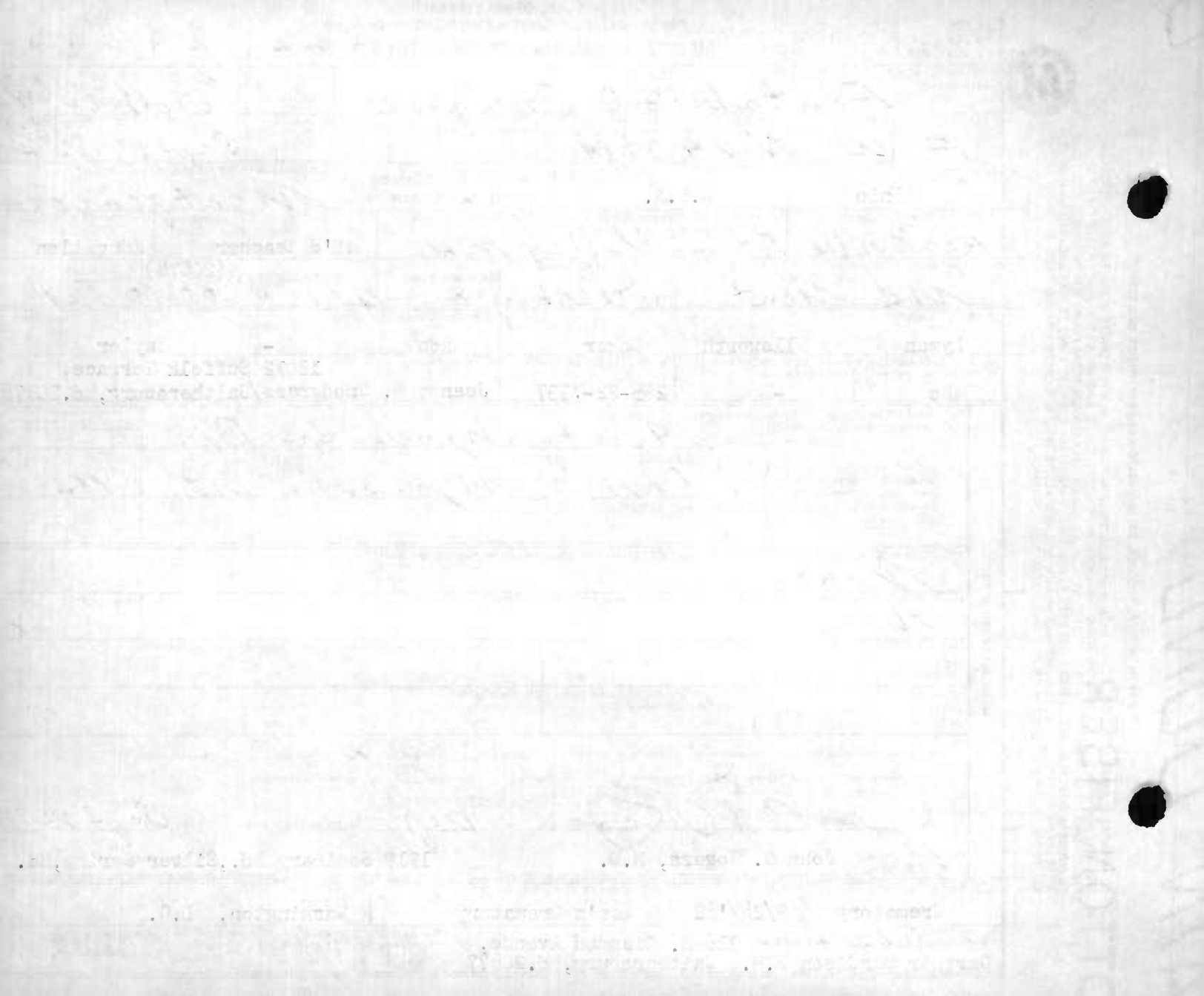
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 4 2 3 4

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|-----------------------------------|--|------------------------------------|--|---------------------------|--|--|--|--------------------|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| Ruth | | J. | | Smith | | | | 26. DATE OF DEATH | | 27. MONTH | | 28. DAY | | 29. YEAR | | 30. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | 10. MONTH | | 11. DAY | |
| Female | | Caucasian | | 4-12-1905 | | 77 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 26. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. NEVER MARRIED | | 10. WIDOWED | | 11. DIVORCED | | 12. BALTIMORE CITY OR COUNTY OF DEATH | | 13. MONTH | | 14. DAY | |
| Georgia | | USA | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | Montgomery | | 27. MONTH | | 28. DAY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. CITY OR TOWN | | 14. STREET ADDRESS | | 15. CITY OR TOWN | | 16. STREET ADDRESS | | 17. CITY OR TOWN | |
| Wheaton | | 2715 Urbana Drive | | Housewife | | Own Home | | Wheaton | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | | Wheaton | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. CITY OR TOWN | | 15. STREET ADDRESS | | 16. CITY OR TOWN | | 17. STREET ADDRESS | |
| Maryland | | Montgomery | | Wheaton | | YES | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | 19. CITY OR TOWN | | 20. STREET ADDRESS | | 21. CITY OR TOWN | | 22. STREET ADDRESS | |
| Zachary | | Alice | | 255-24-5123 | | Elizabeth Holden | | see 13 E | | Wheaton | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | 19. CITY OR TOWN | | 20. STREET ADDRESS | | 21. CITY OR TOWN | | 22. STREET ADDRESS | | 23. CITY OR TOWN | |
| No | | 255-24-5123 | | Elizabeth Holden | | see 13 E | | Wheaton | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | | Wheaton | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. (b) | | 22. DUE TO, OR AS A CONSEQUENCE OF | | 23. (c) | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 25. CITY OR TOWN | | 26. STREET ADDRESS | |
| 1629 | | Metastatic Carcinoma | | DUE TO, OR AS A CONSEQUENCE OF | | Carcinoma of Lung | | DUE TO, OR AS A CONSEQUENCE OF | | | | 2 YRS | | Wheaton | | 2715 Urbana Drive | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 27. None | | 28. CITY OR TOWN | | 29. STREET ADDRESS | | 30. CITY OR TOWN | | 31. STREET ADDRESS | | 32. CITY OR TOWN | | 33. STREET ADDRESS | | 34. CITY OR TOWN | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21. YES | | 22. NO | | 23. CITY OR TOWN | | 24. STREET ADDRESS | | 25. CITY OR TOWN | | 26. STREET ADDRESS | |
| None | | | | YES | | NO | | Wheaton | | 2715 Urbana Drive | | Wheaton | | 2715 Urbana Drive | | Wheaton | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 22. CITY OR TOWN | | 23. STREET ADDRESS | | 24. CITY OR TOWN | | 25. STREET ADDRESS | | 26. CITY OR TOWN | | 27. STREET ADDRESS | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | 22. CITY OR TOWN | | 23. STREET ADDRESS | | 24. CITY OR TOWN | | 25. STREET ADDRESS | | 26. CITY OR TOWN | | 27. STREET ADDRESS | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 22. CITY OR TOWN | | 23. STREET ADDRESS | | 24. CITY OR TOWN | | 25. STREET ADDRESS | | 26. CITY OR TOWN | | 27. STREET ADDRESS | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | 22. CITY OR TOWN | | 23. STREET ADDRESS | | 24. CITY OR TOWN | | 25. STREET ADDRESS | | 26. CITY OR TOWN | | 27. STREET ADDRESS | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy | | 22c. Inspection | | 22d. Inquiry | | 22e. and in my opinion | | 22f. death resulted from: | | 22g. Natural causes | | 22h. Accident | | 22i. Suicide | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy | | 22c. Inspection | | 22d. Inquiry | | 22e. and in my opinion | | 22f. death resulted from: | | 22g. Natural causes | | 22h. Accident | | 22i. Suicide | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy | | 22c. Inspection | | 22d. Inquiry | | 22e. and in my opinion | | 22f. death resulted from: | | 22g. Natural causes | | 22h. Accident | | 22i. Suicide | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy | | 22c. Inspection | | 22d. Inquiry | | 22e. and in my opinion | | 22f. death resulted from: | | 22g. Natural causes | | 22h. Accident | | 22i. Suicide | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy | | 22c. Inspection | | 22d. Inquiry | | 22e. and in my opinion | | 22f. death resulted from: | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 2 | 2 | 4 | 2 | 3 | 5 |
|--|--|------------------|--|--|--|--|--|--|--|--------------------------------|--|--|---|-----------------------------------|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | | 2. DATE KNOWN OF DEATH | | | | | | 3. MONTH DAY YEAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Fontabelle O. Snodgrass | | | | | | 2a. DATE KNOWN OF DEATH Sept 23 1982 | | | | | | 3. MONTH DAY YEAR 09 23 82 | | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 4 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD Sept 23 1982 | | 8. MONTH DAY YEAR 09 23 82 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Potomac Valley N.H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Teacher | | | | 12b. KIND OF BUSINESS OR INDUSTRY Education | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE MD | | | | | | 13b. CITY OR TOWN Gaithersburg | | | | | |
| 13a. STATE MD | | | | | | 13b. CITY OR TOWN Gaithersburg | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Lyman Ellsworth Baker | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Ada Taylor | | | | | | 16. STREET ADDRESS (20878) 12012 Suffolk Terrace, Gaithersburg, Md. 20878 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. 295-22-7337 | | | | | | 17. INFORMANT Jeanne E. Snodgrass | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) None | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | | | TITLE (SPECIFY) M.D. | | | | | | DATE SIGNED Sept 23 1982 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | | | | | ADDRESS 1919 Seminary Rd., Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Crematory | | | | 23b. DATE 9/24/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR Gartner Sandison F.H. | | | | | | ADDRESS 316 E. Diamond Avenue, Gaithersburg, Md. 20877 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | | | | |
| | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

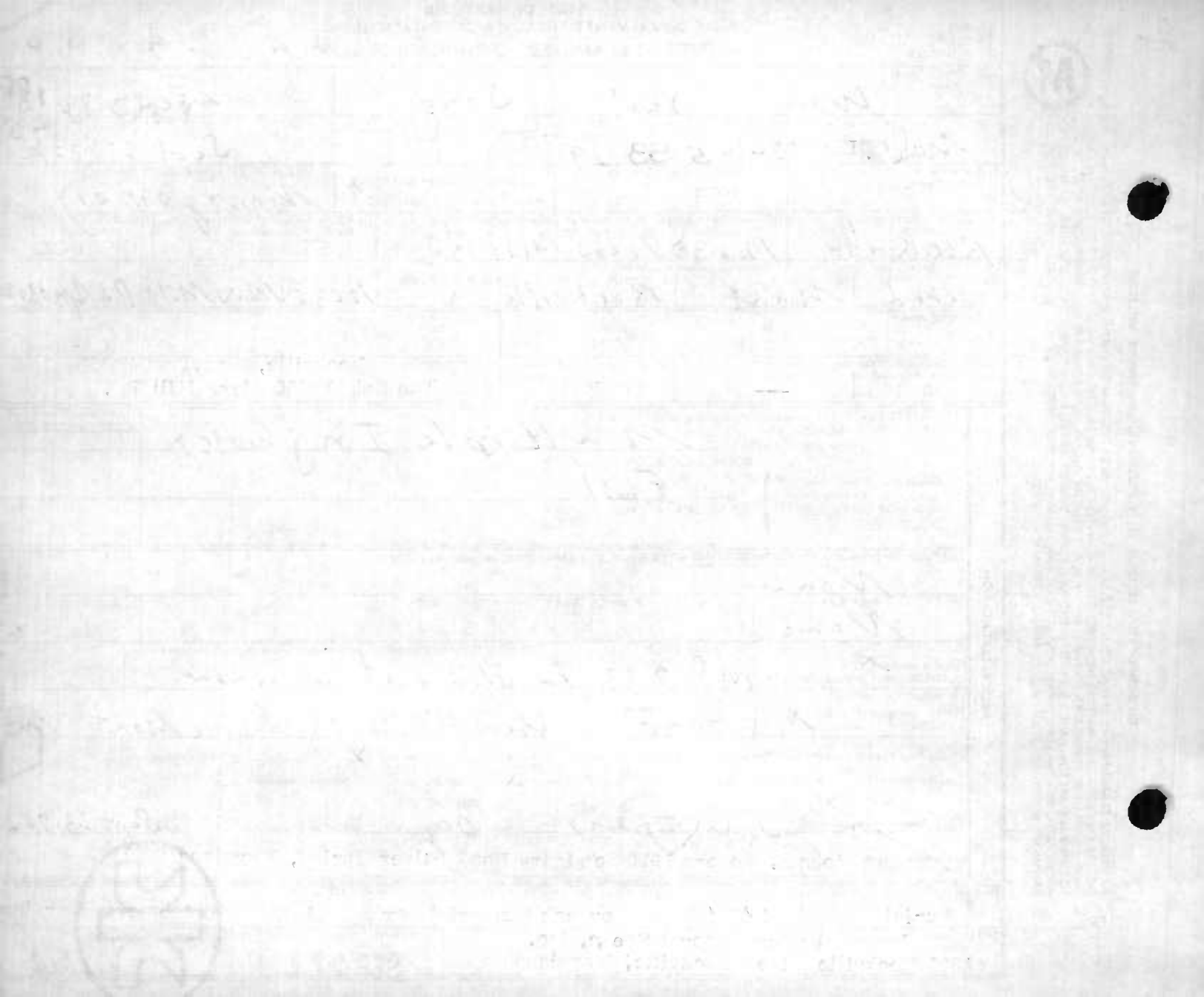
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Won Yeal Song | | | 2a. DATE KNOWN OF DEATH ESTIMATED Sept 23, 1982 | | | 2b. MONTH DAY YEAR 18 | | |
| 3. SEX Male | 4. RACE ORIENTAL | 5. DATE OF BIRTH July 5, 1953 | 6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD Sept 23, 1982 | 7d. MONTH DAY YEAR 19 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea | | 7b. CITIZEN OF WHAT COUNTRY? Korea | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12630 Viers Mill Rd | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | |
| 13a. STATE MD | | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BONG KAN SONG | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOON TAN PAK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Rockville, Maryland 20853 Soon Tan Pak 12630 Viers Mill Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Fall (b) Fall DUE TO, OR AS A CONSEQUENCE OF (c) Fall | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1000 P.M. 9/23/82 | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 1000 P.M. 9/23/82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Slid out window | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Viers Mill Rd. Rockville Mont MD | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | TITLE (SPECIFY) M.D. | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | ADDRESS 1919 Seminary Road Silver Spring, Maryland 20910 | | | DATE Sept 23/1982 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clemy Montgomery Maryland | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1982 | | |
| ADDRESS 1331 Rockville Pike Rockville, Maryland | | | | | | 25b. REGISTRAR'S SIGNATURE J. Canfield | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours. Both with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

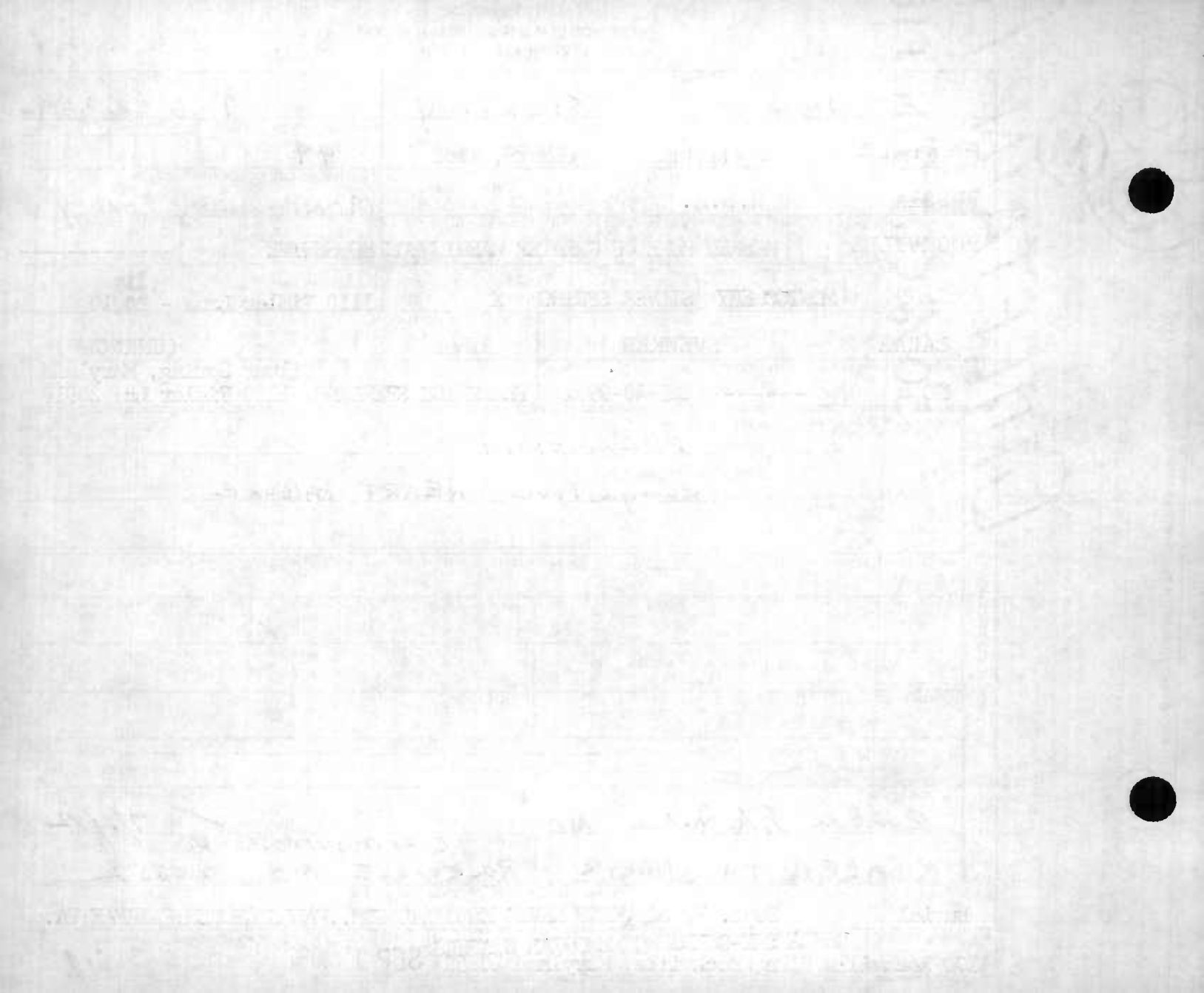
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 3 7 REG. NO. | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST MIDDLE LAST ANNA SPERLING | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-6-82 | | | |
| 3. SEX FEMALE | | | | 2b. HOUR 2 AM | | | |
| 4. RACE WHITE | | | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 29, 1888 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN SILVER SPRING | | | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS 1110 Fidler Lane - 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LAZAR SVENKEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REVA (UNKNOWN) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-40-9991 | | | |
| 17. INFORMANT Silver Spring, Maryland FREDERICK SPERLING; 1110 Fidler La; 20910 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF, (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF, (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Ramleki J.A. Shakir MD | | | | 22c. DATE SIGNED 9/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMLEKI J.A. SHAKIR | | | | 22e. ADDRESS 6121 MONTROSE RD ROCKVILLE MD 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 7, 82 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GDN.; FALLS CHURCH; FAIRFAX; VA. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | | | |

MEDICAL CERTIFICATION



BP _____
 DHMH - 16 50M 1/81
 (VRA 15, 4)

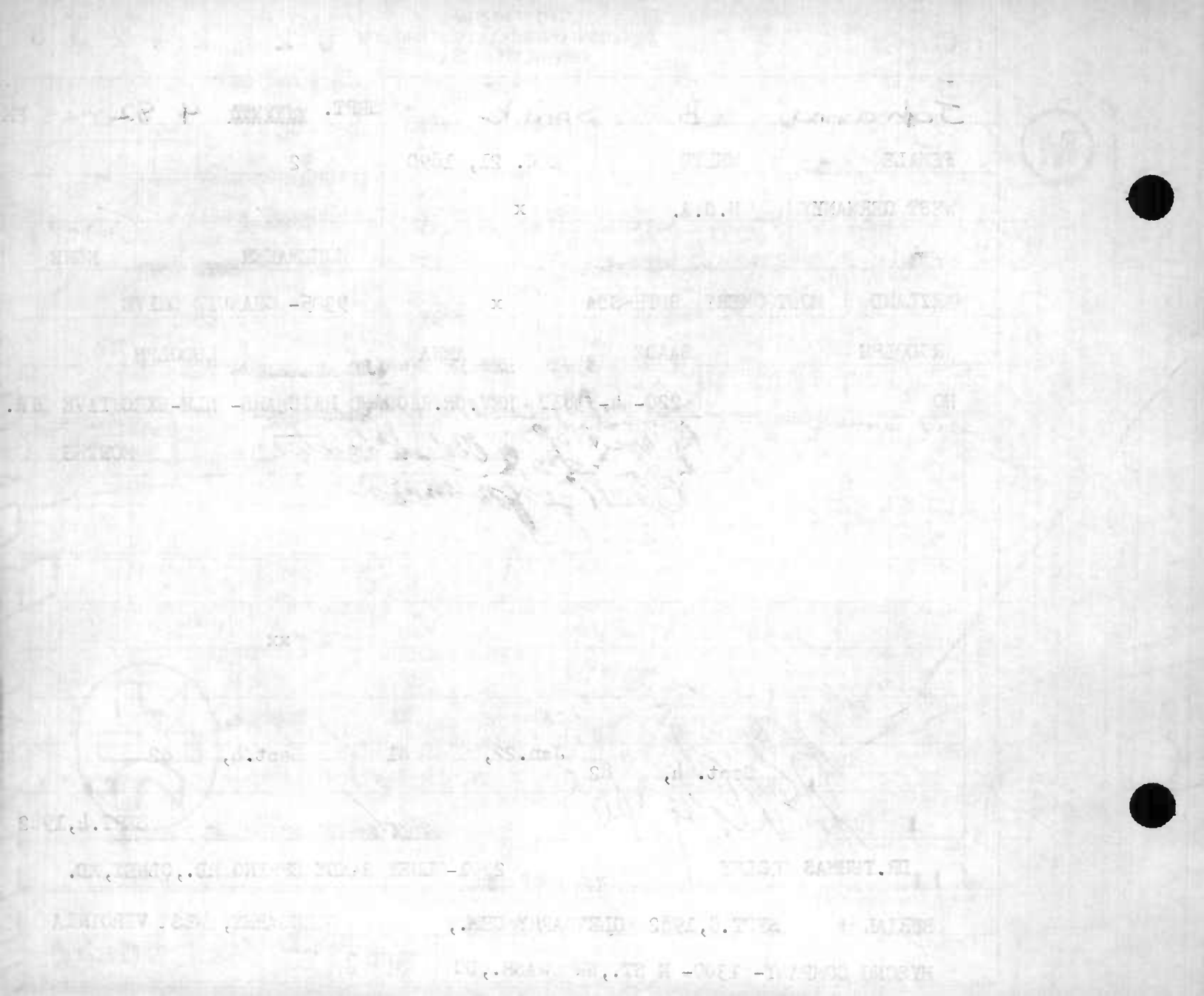
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 3 8 | | | |
|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Johanna B. Sprick | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. AUGUST 4 82 | | | | 2b. HOUR 0925 PM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 21, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | | | | |
| 13a. STATE MARYLAND | | | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RUDOLPH | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMNA LUDOLPH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 220-44-8381T | | 17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD- NLH-EXECUTIVE DIR. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Blood Loss Anemia (c) Cholel Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 22, 19 81, to Sept. 4, 19 82, that (I) (we) last saw the deceased alive on Sept. 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE DR. THOMAS DOOLEY | | | | DEGREE | | | | 22c. DATE SIGNED SEPT. 4, 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THOMAS DOOLEY | | | | 22e. ADDRESS 2901-OLNEY SANDY SPRING RD., OLNEY, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE SEPT. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY GLENGARRY CEM., | | 23d. LOCATION CITY OR TOWN COUNTY STATE GLENGARRY, WEST VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR NAME HYSONG COMPANY- 1300- N ST., NW WASH., DC | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

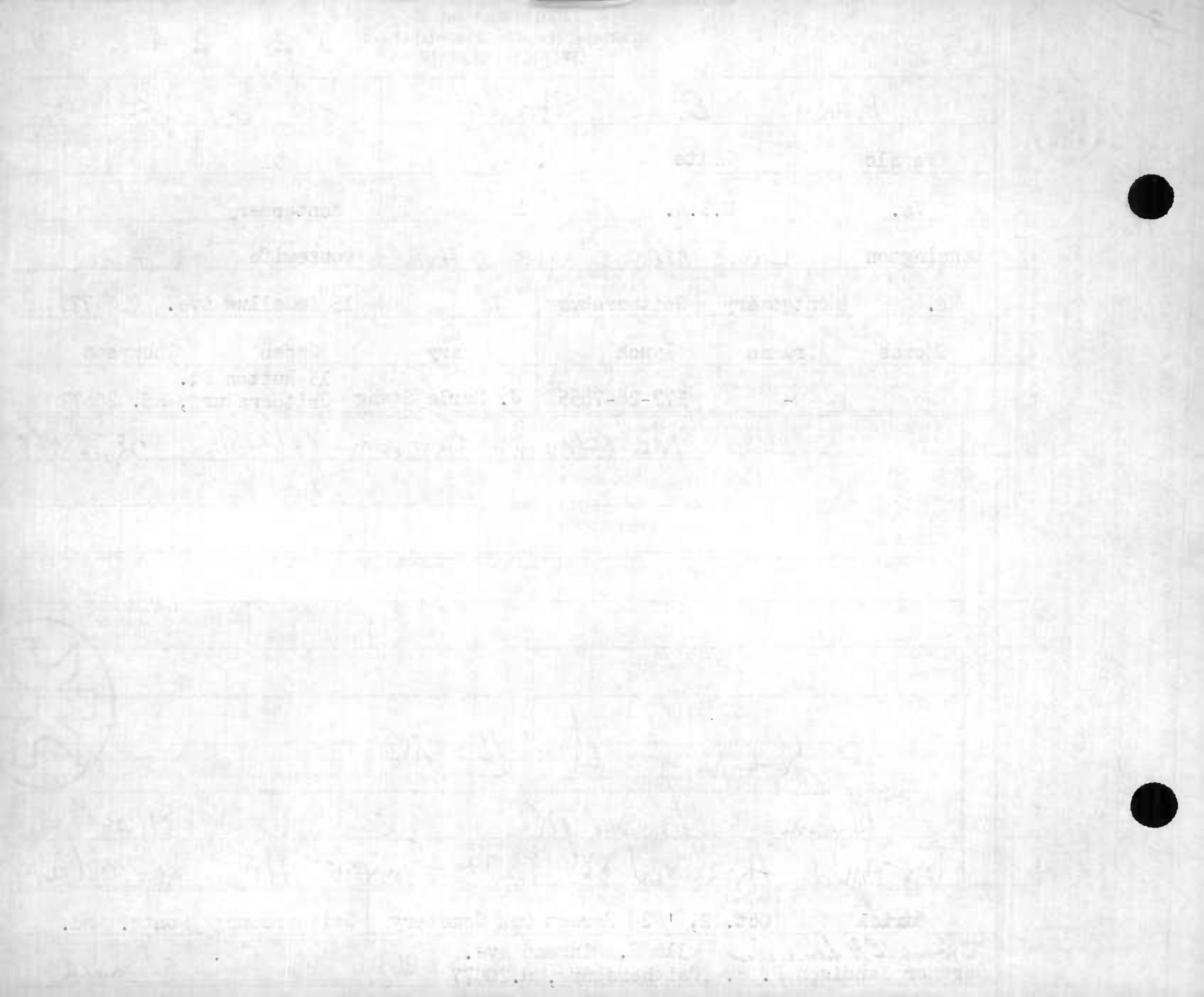
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 4 2 3 9 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST Stang | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 29 1982 | | 2b. HOUR 8:15 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 1 91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CIRCLE MANOR NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 15 DeSillum Ave. (20877) | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE Truman LAST Lynch | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ogden LAST Thompson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT J. Merle Stang | | 15 Hutton St. Gaithersburg, Md. 20877 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | |
| PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Prostate | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from April 16, 1985, to September 29, 1982, and that (2) (our) opinion death occurred on the date and hour and from the causes stated above; (3) we did not see the body after death. | | | | | | | | | |
| 22b. SIGNATURE Bryan | | 22c. DATE SIGNED 9/29/82 | | 22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS 3720 Forest Ave. Gaithersburg, Md. 20877 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 2, '82 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md. | | | |
| 24. FUNERAL DIRECTOR Robert H. Sandison Gartner Sandison F. H. | | 316 E. Diamond Ave. Gaithersburg, Md. 20877 | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1982 | | 25b. REGISTRAR'S SIGNATURE Joan J. Canine | | | |

MEDICAL CERTIFICATION



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| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
|--|--|--|--|--|---|-----------------------------------|---|------|--|--|
| Bernice E. Stansbury | | | | | 09 | 21 | 82 | | 9 ²⁶ A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | White | 8 MONTH 31 DAY 1904 | | 78 YRS. | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | U. S. A. | | | Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Takoma Park | Washington Adventist Hospital | | | Buyer-Ida's Dept. Store | | 20812 | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | | | | | |
| Maryland | Montgomery | Takoma Pk. | | 7719 Eastern Ave., #37 | | | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| David O'Brien | Anne Carter | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | | | | | | |
| No | --- | 577-03-3646 | 12904 Middlevale Ln. Freemont N. Stansbury, Jr. Wheaton, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>cardiac arrest</u> | | | | | | | | | 30 min | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> | | | | | | | | | 4 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>74</u> to <u>SEPT.</u> 19 <u>82</u> , that (I) (we) lost | | | | | | | | | | |
| saw the deceased alive on <u>SEPT. 21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| <u>Robert L. Krichmar</u> | | MD | | | SEPT. 21 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| ROBERT L. KRICHMAR MD. | | 7733 ALASKA AVE. N.W. WASHINGTON D.C. 20012 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | 9/24/82 | | Ft. Lincoln Cemetery | | Brentwood Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | P.O. Box 7428 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Warner E. Pumphrey, Inc., Sil. Spr., Md. | | | | SEP 27 1982 | | <u>John J. Smith</u> | | | | |

SEP 22 12:40

11-22-72

317137

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]
[illegible]

RE: [illegible]
[illegible]
[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

[illegible]
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[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

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MEDICAL CERTIFICATION

| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
|---|--|--|--|--|--|---|--|--|--|-----------------------------------|--|
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | MONTH DAY YEAR | | | |
| Henry Lawrence Stauffer | | | | Sept 3, 1982 | | | | 2:33 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| Male | | Caucasian | | Feb 2 1922 | | 60 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | USA | | | | Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | 10710 Blossom Lane | | | | Engineer | | | | US Navy Dept. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10710 Blossom Lane | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Harry Stauffer | | | | Ruth Steinberger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| Yes | | | | WWII | | | | 184-12-6620 Irene Stauffer | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 2028 | | | | Acute lymphoma | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | 2 years | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | Myocardial ischemia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 1952, to Sept. 3, 1982, that (I) (we) last saw the deceased alive on Sept. 3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Raymond Bradshaw, MD | | | | | | | | Sept. 3, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Raymond Bradshaw | | | | 345 University Blvd. W Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 9-7-1982 | | Gate of Heaven | | Silver Spring | | Montgomery | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hines/Rinaldi Funeral Home | | 11800 N.H. Avenue, S.S. Md. | | SEP 9 1982 | | John J. Connel | | | | | |

Montgomery County

1971-1972

Silver Spring, Maryland

State of Maryland

1971-1972

County

1100 N. Avenue

1971-1972

Montgomery County, Maryland

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 4 2 REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RICHARD ALLEN STEINBACH | | | | 20. DATE OF DEATH MONTH DAY YEAR 2b HOUR SEPT 9 1982 5¹⁰ A.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 5 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ATLANTA, GA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6604 Tulip Hill TERC. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Simeon Verome Steinbach | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda -- Fromer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 169 24 4637 | | 17. INFORMANT Wife | | ADDRESS Same as #13 | |
| 16c. (IF YES, GIVE WAR OR DATES) Korean | | | | 17. INFORMANT Maureen Ryan Steinbach | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 year | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 81 , 19 81 , to Sept 9 , 19 82 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 7/30/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | |
| 22b. SIGNATURE John C. Harvey M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 9 Sept 1982 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Harvey M.D. | | | | 22c. ADDRESS Georgetown Hospital 3800 Reservoir Rd. N.W. Wash. D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE Sept 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Gabriels Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Potomac Montgomery Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. DeSole ADDRESS 2222 Wisconsin Ave. N.W. Washington D.C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "NOTICE" and "RECEIVED" are faintly visible.]

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 4 3 REG. NO. | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK H. STEINER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-14-82 | | | | 2b. HOUR 5:43 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8-20-26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY P.O. Employee | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William F. Steiner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia M. Carter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. WW 11 220-12-4133 | | 17. INFORMANT ADDRESS Betty L. Steiner-wife- (same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of bladder. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH no year 3 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1889 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE SILVER SPRING Md. 20910 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 9/13 19 82 , to Sept 14 19 82 , that (we) last saw the deceased alive on 9/13 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE James Coleman III | | | | DEGREE MD | | | | 22c. DATE SIGNED 9-15-82 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN | | | | 22b. ADDRESS 9241 COLUMBIA BLVD. SILVER SPRING Md. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave., ADDRESS S.S. Md. 20904 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 4 4 REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Mary Jane Stringer</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>9-16-82</u> | | 2b. HOUR <u>12⁰¹ AM</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>12 05 15</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ohio</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County, MD.</u> | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13b. STREET ADDRESS <u>10401 Grosvenor Place</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Not Available Tappe</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Welling</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>578-34-6286</u> | | 17. INFORMANT <u>Debbie Stringer, Daughter, Same as item #13</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1809</u> IMMEDIATE CAUSE (a) <u>CARCINOMA OF CERVIX, METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 82</u> to <u>9/16 19 82</u> , that (I) (we) last saw the deceased alive on <u>9/15/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Ralph M. Cavan M.D.</u> | | DEGREE <u>M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/16/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RAUPH M. CAVAN M.D.</u> | | 22e. ADDRESS <u>4400 EAST WEST HWY, BETHESDA, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>Sept. 16, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory Alexandria</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Virginia</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 22 1982</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Cawley</u> | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

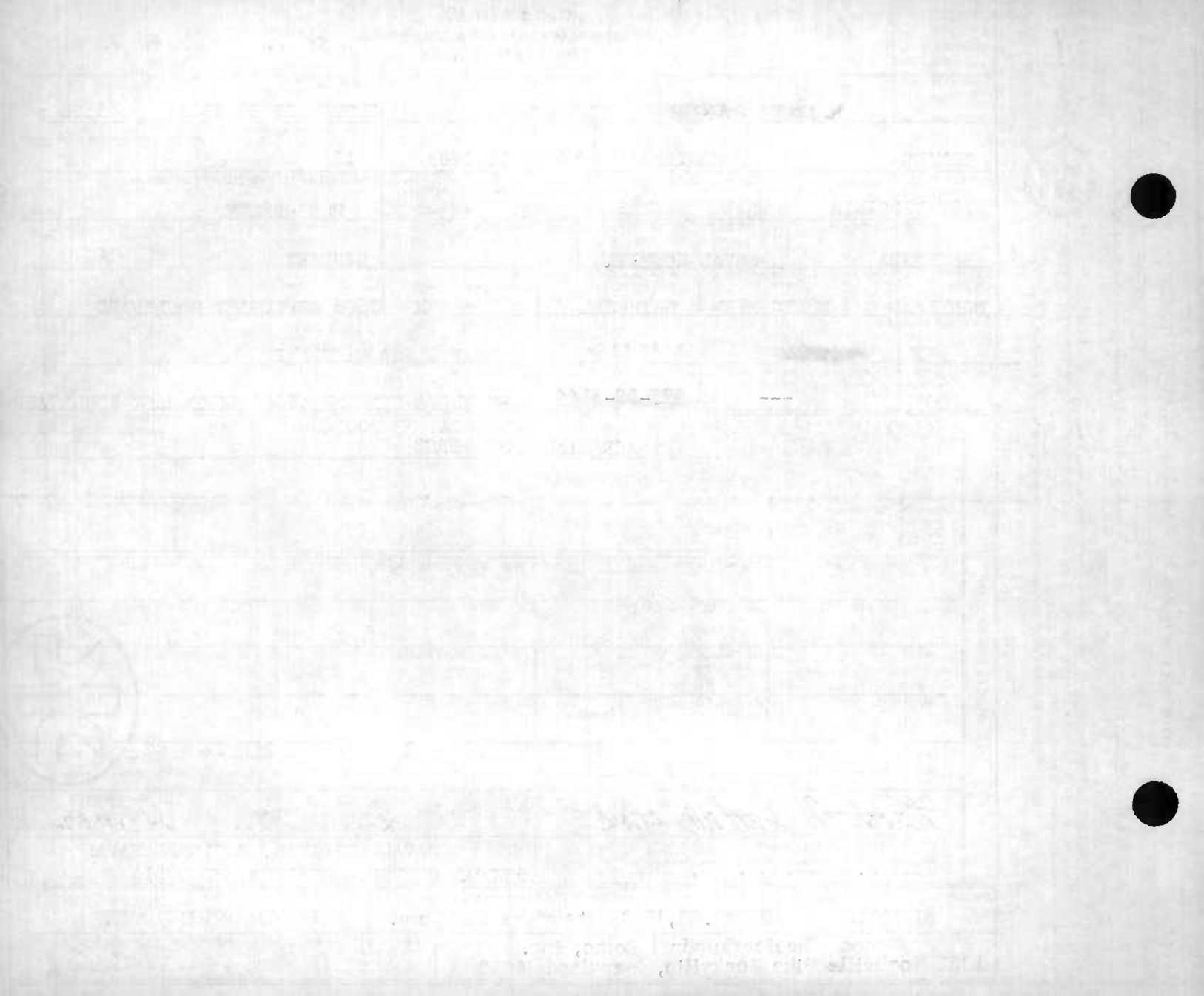
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 4 5 | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HEATHER S'ANNE STROHMER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24 1982 | | 2b. HOUR 1:00 PM | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 13 1969 | | 6. AGE (IN YEARS LAST BIRTHDAY) 13 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7505 DEMOCRACY BOULEVARD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN M'ACIAG | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELENA STROHMER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 577-98-5144 | | 17. INFORMANT ADDRESS MARY ELENA STROHMER, 7505 DEMOCRACY BOULEVARD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4329 IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE BETHESDA, MD 20034 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 23 19 82 , to SEPTEMBER 24 19 82 , that (I) (we) last saw the deceased alive on SEPTEMBER 24 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Brett A. Scott</i> LT, MC | | | | | | DEGREE | | 22c. DATE SIGNED 24 SEP 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRETT A. SCOTT, LT, MC, USNR | | | | | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE SEPT. 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ryson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

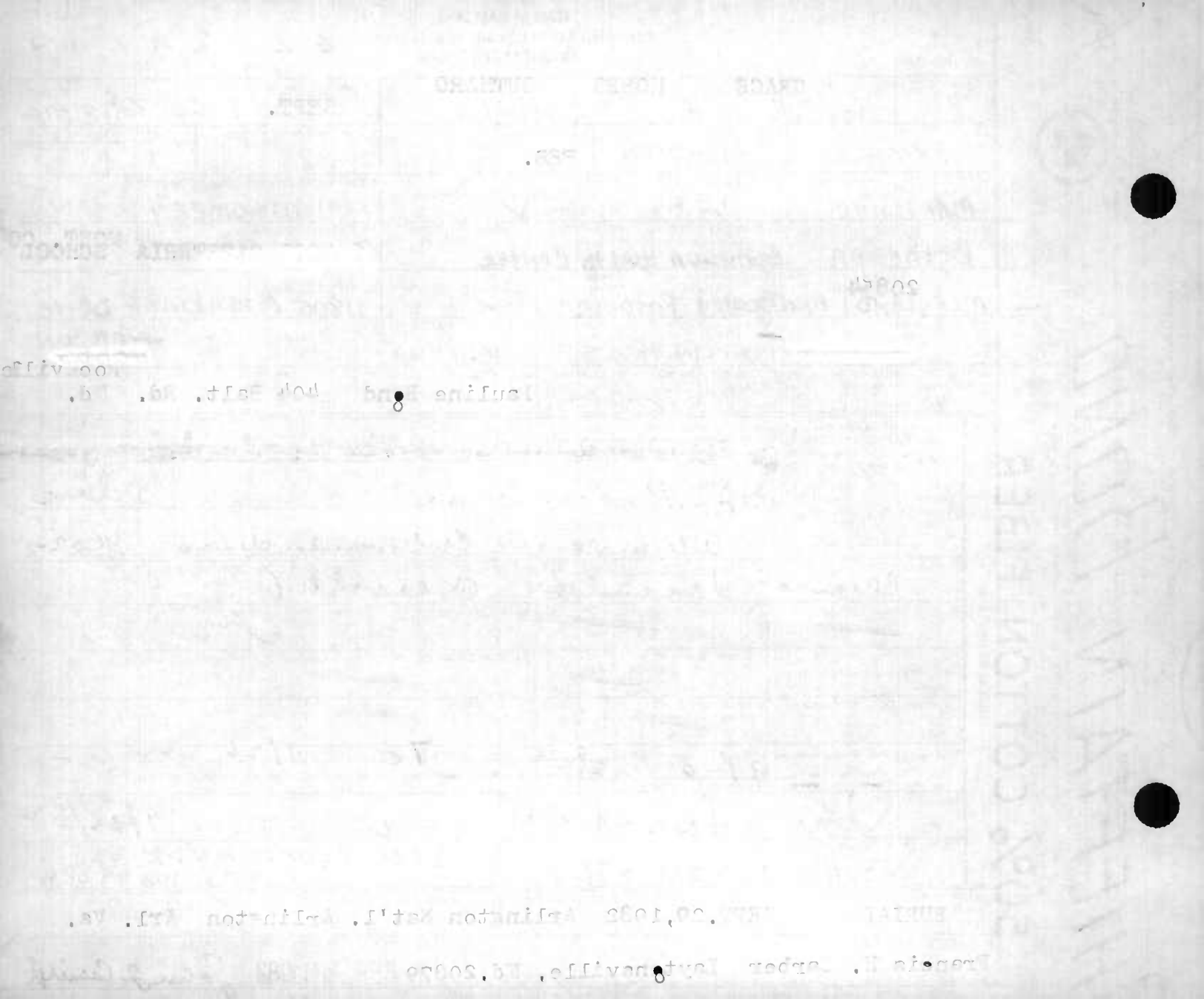
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

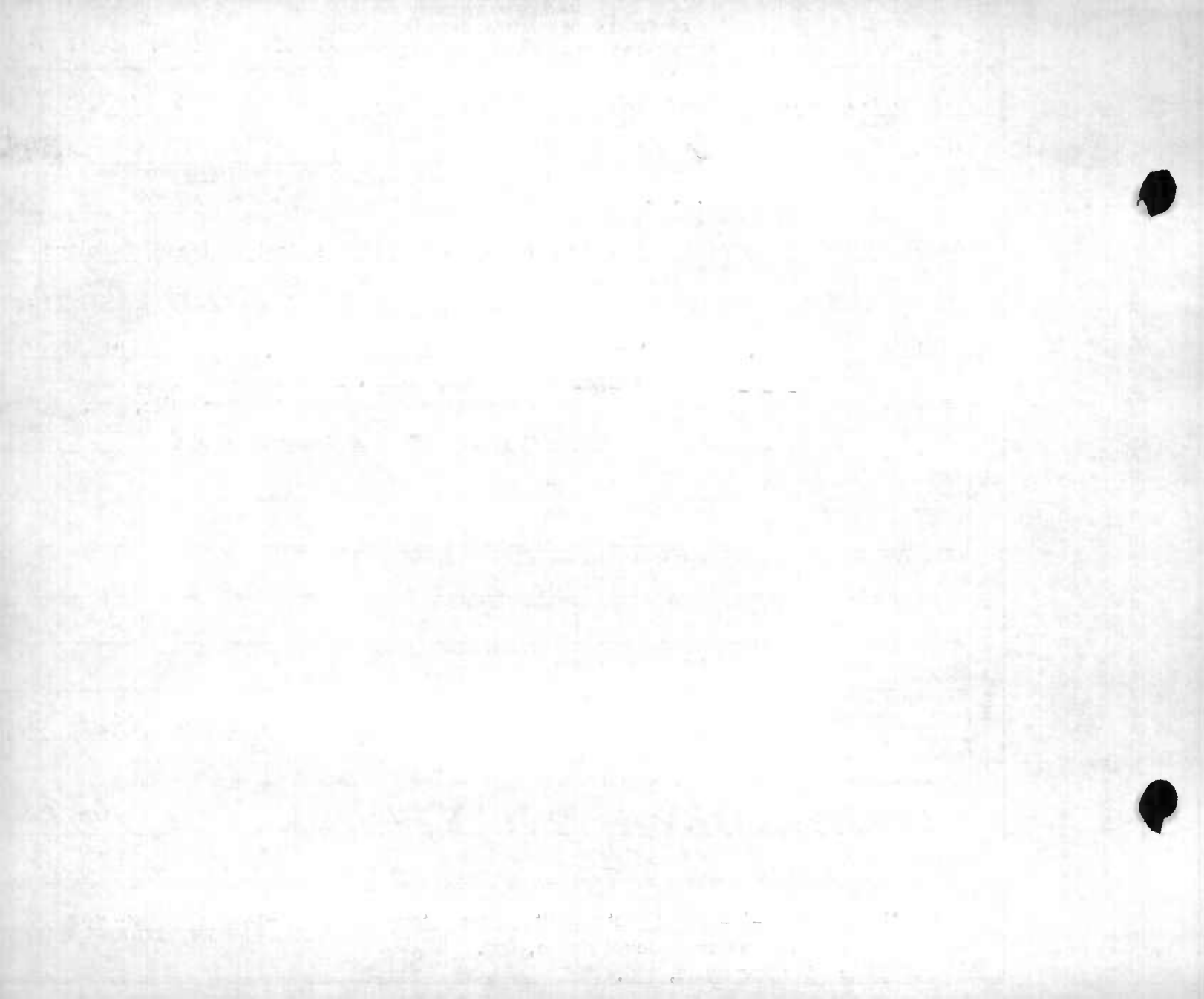
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 4 6 REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST GRACE MIDDLE HOBBS LAST SUTHARD GRACE H. SUTHARD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. -26-82 | | | 2b. HOUR 8:30 AM | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH FEB. 26 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center | | | | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) SCHOOL CAFETERIA | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 20854 13b. COUNTY Montgomery 13c. CITY OR TOWN Potomac | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11805 ROSALINDA DRIVE | |
| 14. FATHER'S NAME FIRST FRANKLIN LAST Hobbs | | | | 15. MOTHER'S MAIDEN NAME FIRST MARTHA MIDDLE JOHNSON | | | | ADDRESS Rockville | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 579-42-0346 | | 17. INFORMANT Pauline Bond | | ADDRESS 404 Balt. Rd. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A Pneumonia (c) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral Vascular Accident | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25, 19 76, to 9/26, 19 82, that (I) (we) lost saw the deceased alive on 9/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 9/26/82 | | | |
| 22b. SIGNATURE John S. Fawcett | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. FAWCETT | | | | | 22e. ADDRESS 16610 SUGARLAND ROAD BOYDS, Md 20841 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE SEPT. 29, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arl. Va. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis H. Barber ADDRESS Laytonsville, Md. 20879 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 2 4 7 | | |
|---|-----------------|---|--|---|---|---|--|---|---|--|---------------------|---------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM WALTER SYLVESTER | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 10 1982 | | 2b. HOUR ? |
| 3. SEX Male | 4. RACE CAUC | 5. DATE OF BIRTH MONTH DAY YEAR 8 2 55 | | 6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS. | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 13 1982 | | 2d. HOUR 3:40 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GERMANTOWN | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19769 CRYSTAL ROCK DR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Engineer | | | 12b. KIND OF BUSINESS OR INDUSTRY Solorex | | | |
| 13a. STATE MD | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN GERMANTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 19769 CRYSTAL ROCK DR | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William W. Sylvester | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne L. Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- -- -- | | 17. INFORMANT ADDRESS Anne Sylvester Adams 804 Bowie Road Rockville, Md. 20852 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9259 IMMEDIATE CAUSE (a) ASPHYXIA - ARGON GAS Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DEPRESSION (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9 10 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) INHALED GAS | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19769 CRYSTAL ROCK DR GERMANTOWN MONT MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Mayle | | | | TITLE (SPECIFY) M.D. <i>Sgt</i> | | | | DATE SIGNED 9/13/82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle | | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

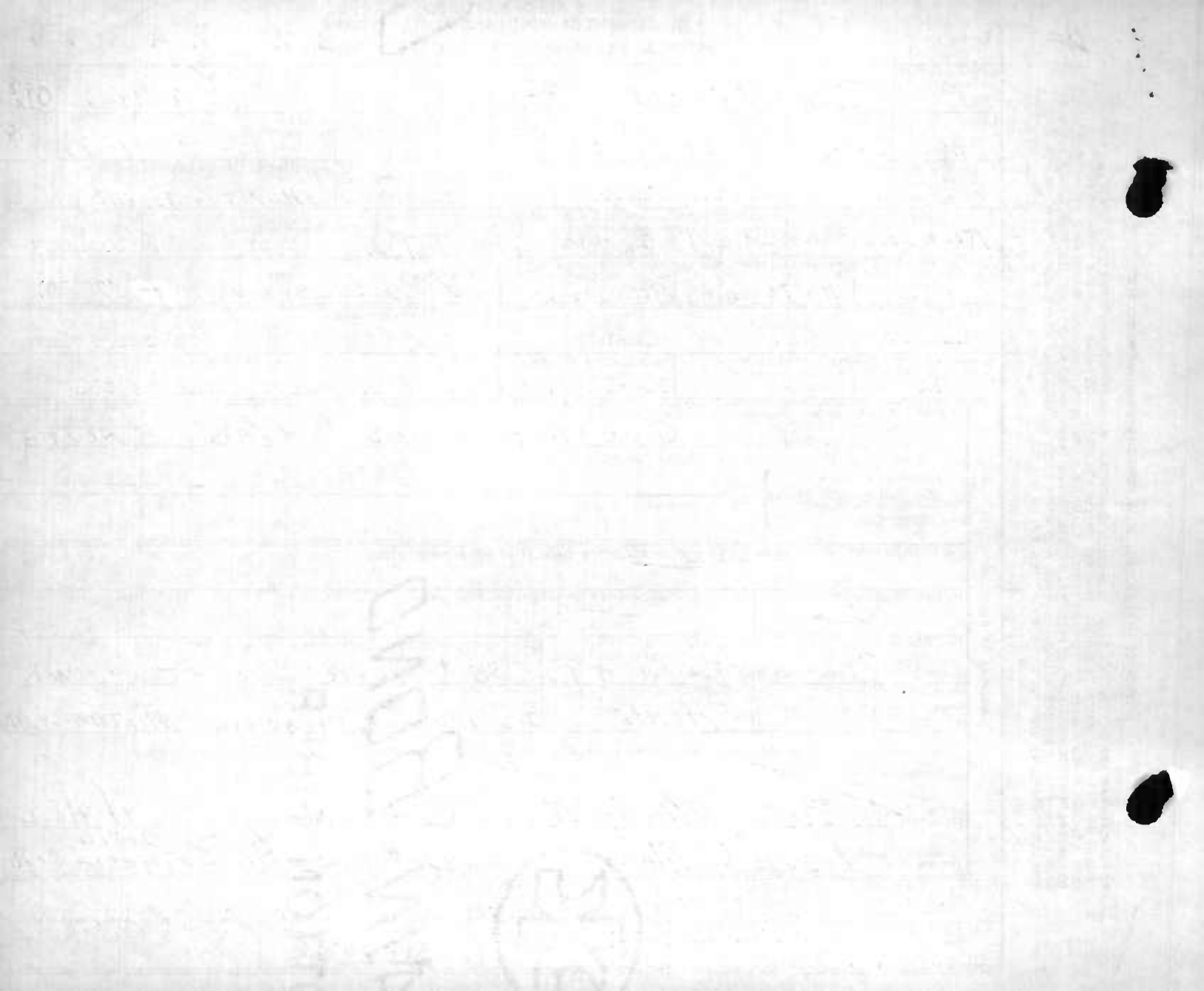
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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 4 2 4 8

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------|------------------|---|--|---|--|---|----------------|---|--|---|--|--|--|---------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST TIMOTHY | | | MIDDLE LEE | | | LAST TANNER | | | 2a. DATE KNOWN OF DEATH | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY 9 19 82 | | YEAR 19 82 | | HOUR 09 18 AM | |
| 3. SEX M | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 7 27 59 | | 6. AGE (IN YEARS) LAST BIRTHDAY 23 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 19 82 | | 2d. HOUR 09 18 AM | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Helper | | | | 12b. KIND OF BUSINESS OR INDUSTRY Auto Body | | | | | | | |
| 13a. STATE MD | | | | | | | | | | 13b. CITY OR TOWN MONTGOMERY ROCKVILLE | | 13c. STREET ADDRESS 202 SPRING Avenue (20850) | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luther E. Tanner | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn VonVodenstien | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 220-74-3736 | | 17. INFORMANT ADDRESS Luther E. Tanner, same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) GUNSHOT WOUND HEAD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 18 PM 9 19 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 38 CALIBER GUNSHOT WOUND | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 202 SPRING St ROCKVILLE MONTGOMERY MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayco | | | | TITLE (SPECIFY) M.D. Dpt | | | | MEDICAL EXAMINER 8200 Wisconsin Ave Bethesda MD | | | | DATE SIGNED 9/19/82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayco | | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1982 | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 4 9 | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rebecca Tenenbaum | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 3, 1982 | | | |
| 3. SEX Female | | | | 2b. HOUR 5:37 P.M. | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 4, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | | |
| 13c. CITY OR TOWN SILVER SPRING | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 11653 Lockwood Drive, #201 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN LEVINE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA PRESSMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 287-30-9296B | | | |
| 17. INFORMANT Silver Spring, Md. 20904 | | | | MILTON SLIFKIN; SON-IN-LAW; 1108 Downs Drive | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from 9/3, 1982 to 9/3, 1982 , that (we) lost saw the deceased alive on 9/3, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Norman H. Rubenstein DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN H. RUBENSTEIN, MD | | | | 22e. ADDRESS 11161 New Hampshire Ave.; Silver Spring, Md. 20904 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Sept. 5, 82 | | 23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens Olney; Montgomery; Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 5 1
REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED (TYPE OR PRINT) BETTY THAYER TEWES | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 1 '82 | | 2b. HOUR 12:15 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Oct 6 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY — |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Rockville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edwin A. Thayer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel Mattei | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579 48 5933 | | 17. INFORMANT HUSBAND ADDRESS Joseph W. Tewes Jr. Same #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALZHEIMER'S 3310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug 19 80 to Sept 1 82 that (I) (we) lost saw the deceased alive on Aug 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Thos G. Ward | | 22c. ADDRESS 6116 ROBINWOOD Bethesda Md 20815 | | 22d. DATE SIGNED 9/1/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR SEP 7 1982 | | | |

24. FUNERAL DIRECTOR

John F. DeVoi **DEVOI FUNERAL HOME** **WASH. DC.**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

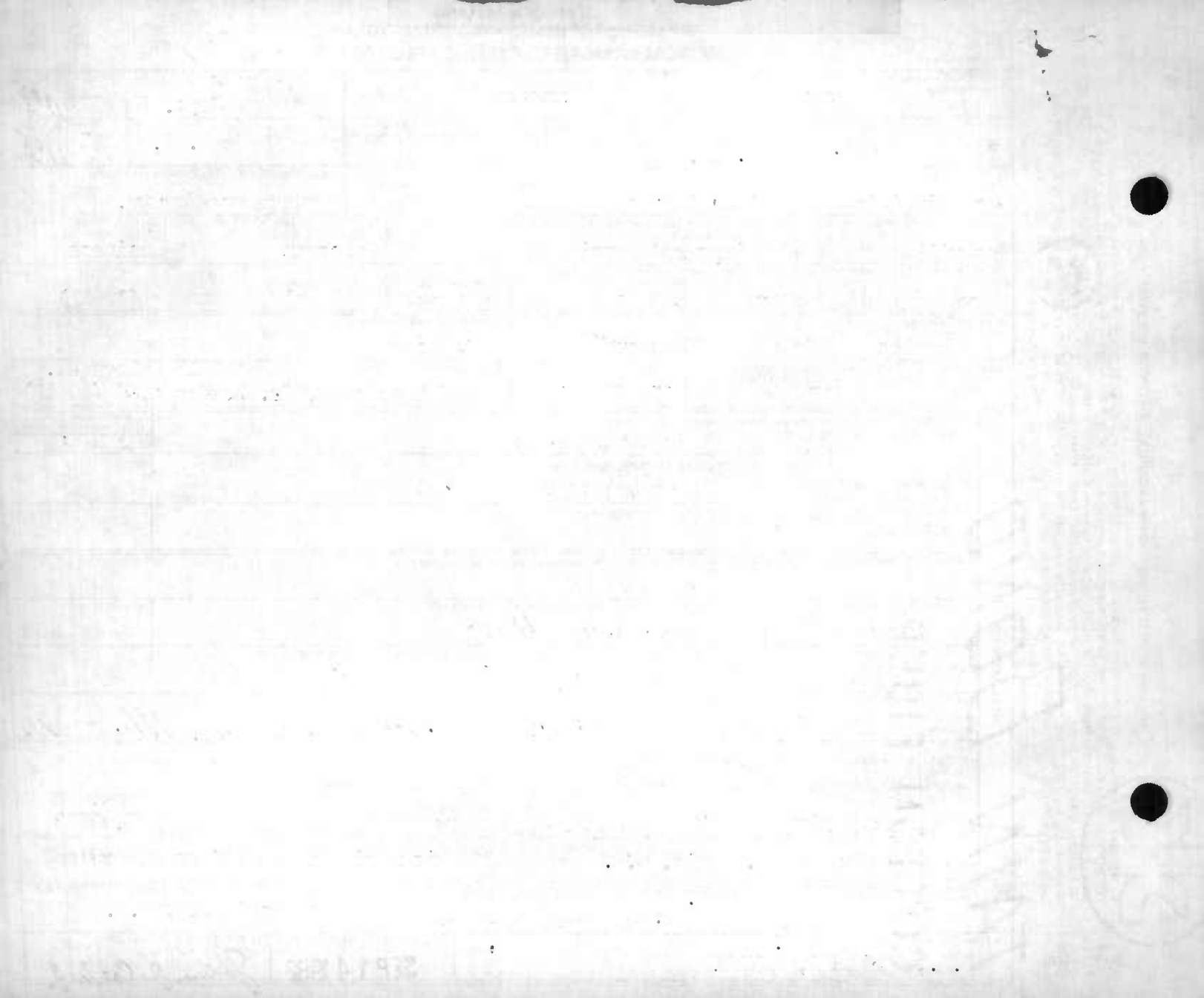
BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-----------|--|----------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. MONTH | | 2c. DAY | | 2d. YEAR | | 2e. HOUR | |
| Edward | | Thackston | | | | | | Sept. 5 | | 19 | | 82 | | 11:05 | | AM | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. MONTH | | 2e. DAY | | 2f. YEAR | |
| Male | Cauca. | Sept. 10, 1895 | | 86 | | YRS. | | | | Sept. 5, | | 19 | | 82 | | 11:05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| West Virginia | | United States | | | | | | Montgomery County, | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Rockville | | Collingswood Nursing Home | | Salesman | | Business | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6013 Walton Road | | | | | | | | (20817) | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Charles Cole | | Romaine Mahan | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | WWI | | 579 44 6008 | | Son | | 6013 Walton Rd. | | | | | | | | | |
| | | | | | | Edward Thackston, Jr. Bethesda, Md | | (20817) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 8880 IMMEDIATE CAUSE (a) PNEUMONIA | | 2 WKS | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: | | | | | | | | | | | | | | | | | |
| (b) FRACTURED Hip | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| 7/10/82 | | FRACTURED Hip | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| | | PSYCHIATRIC INST. | | MEDICAL CENTER D. ROCKVILLE MONT. MD. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| | | Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Francis C. Mayle | | Deputy | | September 7, 1982 | | | | | | | | | | | | | |
| EXAMINER'S NAME Francis C. Mayle, M.D. | | 8200 Wisconsin Avenue Bethesda, Maryland | | | | | | | | | | | | | | | |
| (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | Sept. 8, 1982 | | Rock Creek Cemetery | | Washington, D.C. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | SEP 14 1982 | | John J. Caniff | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

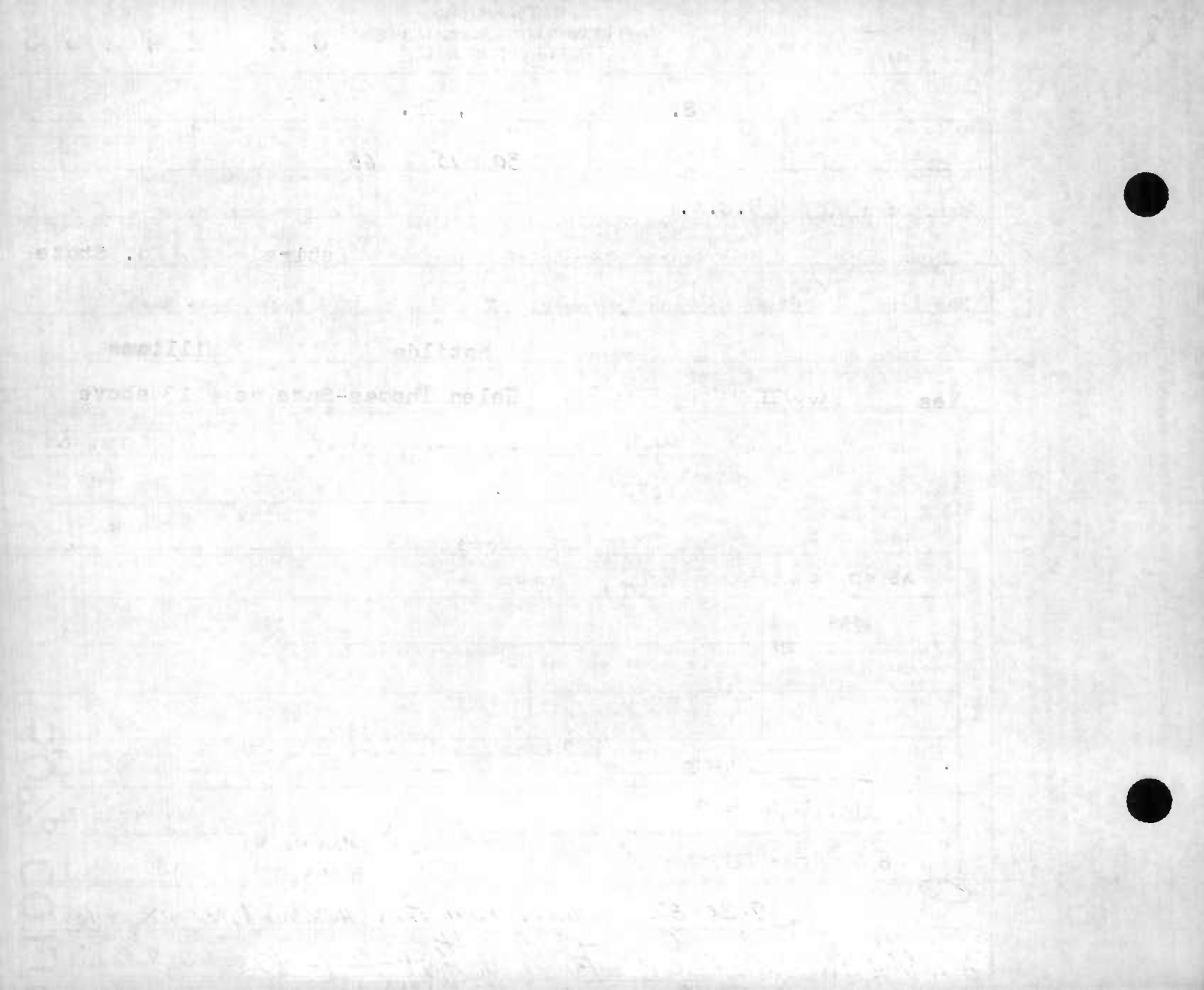
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH-16 (5M 1-8)
(VRA 13, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 2 4 2 5 3 REG. NO. | | | | | | |
|--|--|---|--|--|--|--|---|---|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred S. Thomas, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-26-82 | | | | | 2b. HOUR 7:52am | |
| 3 SEX male | | 4 RACE black | | 5 DATE OF BIRTH MONTH DAY YEAR 11-30-1915 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 7 IF UNDER 24 HRS. HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 8b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Md. State | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Prince Georges Landover | | 13c. CITY OR TOWN Brightseat | | 13d. STREET ADDRESS Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Thomas | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Williams | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT ADDRESS Helen Thomas-Same as # 13 above | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1029 IMMEDIATE CAUSE (a) Acute subpulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema of lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1980 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ASCVD, Diabetes Mellitus, HBP | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 9-2-82, 19_____, to 9-26-82, 19_____, that (I) (we) last saw the deceased alive on 9/22/82, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE MBP aturk ans | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-26-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) 6 B Petrick MD | | | | | 22e. ADDRESS 9321 Coleridge Rd Silver Spring Md 20910 | | | | | | |
| 23a. (BURIAL) CREMATION, REMOVAL (TYPE OR PRINT) | | 23b. DATE 9-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE HIGHLAND PARK P.G. MD. | | | | | |
| 24. "FUNERAL DIRECTOR" H.S. Washington Spc | | | | | ADDRESS 4925 N. H. | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE Joan J. Carver | | |

3402 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 5 4 REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL Thomas XXXXX | | | | MONTH DAY YEAR 9/28/82 | | 2b. HOUR 10 ⁵⁵ AM | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 9/28/82 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 2 59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONT Rockville | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4411 BAYNE ST | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MARK ANTON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ruth THOMAS XXXXXXXXXX | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE | | 17. INFORMANT ADDRESS CAL BOWSER SAME AS 13 GRANDFATHER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Nicholas E. Fidis MD | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NICHOLAS E. FIDIS MD. | | | | 22e. ADDRESS 9045 SHADY GROVE CT. GAITHERSB. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | 25. DATE REC'D. BY REGISTRAR OCT 4 1982 | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 26. REGISTRAR'S SIGNATURE John J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 5 5 REG. NO. | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| VINCENT | | | | THOMAS | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | 9/28/82 | | 9/28/82 10:55 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | USA | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | HOLY CROSS HOSPITAL | | N/A | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| 13a. STATE MARYLAND 13b. COUNTY MONT 13c. CITY OR TOWN Rockville | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| MARK ANTON | | | | RUTH THOMAS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | | | NONE | | CAL BOWSER SAME AS 13 GRANDFATHER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 7651 Immaturity | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| NICHOLAS E. FDIS MD. | | | | MD | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| NICHOLAS E. FDIS MD. | | | | 9045 Shady Grove Ct. - GAITHERSB. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 9/30/82 | | GATE OF HEAVEN | | SILVER SPRING MONT MD. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| FRANCIS J. COLLINS | | | | OCT 4 1982 | | John J. Conner | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| | | | | | |
|--|---|--|---|---|---|
| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 4 2 5 6 REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW N. THOMPSON | | | 2a DATE OF DEATH MONTH DAY YEAR August 30, 1982 | | 2b HOUR 5:00PM |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR 09 27 02 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | 13b COUNTY Montgomery | 13c CITY OR TOWN Sil. Spg. | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS 3544 Chiswick Court |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thompson | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Norby | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17 INFORMANT ADDRESS Alice W. Thompson See Item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 4100 Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cholelithiasis | | | | | |
| 19a DATE OF OPERATION — | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov 14 , 19 79 , to Aug 30 , 19 82 , that (I) (we) last saw the deceased alive on Aug 30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Catherine M. Chura, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 8/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Catherine M. Chura, M.D. | | 22e ADDRESS 1811 Prince Philip Drive Olney, Md. 20832 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 31 Aug. 1982 | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24 FUNERAL DIRECTOR NAME J. William Lee's Sons Co. | | 300 4th st. N.E. ADDRESS Wash., D.C. 20002 | | 25a. DATE REC'D. BY REGISTRAR SIGNATURE SEP 7 1982 John J. Conner | |

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 5 7 REG. NO. | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN THOMPSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 26 82 | | | | 2b. HOUR 10:25 PM | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILL | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Montg | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1235 Potomac Valley Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fred unk Krumhan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muddy unk unk | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None | | 16b. SOCIAL SECURITY NO. unk | | 17. INFORMANT Dr Wm. F. Thompson | | ADDRESS 3207 Amberley Fairfax VA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4360 DUE TO, OR AS A CONSEQUENCE OF (b) PRIOR CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Fast min 1 2 1/2 months | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) CORONARY HEART DISEASE | | | | | | | |
| 19a. DATE OF OPERATION 9 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1 19 71, to SEPT 26 19 82, that (we) last saw the deceased alive on 9-26 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 9-27-82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joel A. Reiskin, MD | | | | 22e. ADDRESS 809 VERNIS MILL RD, ROCKVILLE, MD 20851 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Spartanburg P.G. Md | | | | | |
| 24. FUNERAL DIRECTOR NAME W.W. Chambers Co | | | | 24b. ADDRESS 8655 Georgia Ave Silver Spg Md | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1982 | | 25b. REGISTRAR'S SIGNATURE J. G. ... | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 5 8 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILMA DOROTHY TIFFANY | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 19 1982 | | 2b. HOUR 8:15 P.M. | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 12 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY PRINCE GEO'S | | 13c. CITY OR TOWN TEMPLE HILLS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WAVERING | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIA HECKEMKAMP | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 566-28-5525 | | 17. INFORMANT ADDRESS WILLIAM B. TIFFANY, ROUTE 1, BOX 313, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5712 massive ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (b) G.I. HEMORRAGE DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLIC CIRRHOSIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 2, 19 82 to SEPTEMBER 19 19 82 , that (I) (we) lost saw the deceased alive on SEPTEMBER 19, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE M.S. Miller | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.S. MILLER, LT, MC, USNR | | 22e. ADDRESS NAVAL HOSPITAL, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington | | 23d. LOCATION CITY OR TOWN COUNTY STATE Va. | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | 25. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | |

 REGISTRAR'S SIGNATURE
John P. Calver

566-28-2522

Initial 9/23/82 Arlington National Cemetery

O. P. Kline (160 Oxon Hill Rd. Oxon Hill, Md. 20546)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 5 9 REG. NO. | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FANNIE TOKER | | | | 2a. DATE OF DEATH MONTH 9 DAY 23 YEAR 82 HOUR 8:52 P.M. | | | |
| 3. SEX FEMALE | | 4. RACE JEWISH | | 5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Manor N. Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY N/A. | |
| 13a. STATE MD. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Julius MIDDLE Nochemowitz LAST Rachel | | 15. MOTHER'S MAIDEN NAME FIRST Rachel MIDDLE Jaffee LAST Jaffee | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 119-44-8888 | | 17. INFORMANT Dr. Cyril Toker ADDRESS 9417 Winterset Ave. Md. Pot. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Cancer, metastatic, Primary undetermined DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION 9-23-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 9-23-82 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-23-82 , 19 82 , to 9-23-82 , 19 82 , that (I) (we) last saw the deceased alive on 9-23-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Morris Perry | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-23-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morris Perry | | 22e. ADDRESS 11602 Georgia Ave. Silver Spring Md 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY Judeon Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Olney Mont. Md. | |
| 24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. ADDRESS 8434 Ga. Ave. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

1. The purpose of this report is to provide a summary of the results of the study conducted during the period from January 1, 1961, to December 31, 1961. The study was conducted in order to determine the effect of the new program on the economy of the country.

2. The study was conducted by the Department of the Interior, Bureau of Land Management, and the Department of the Army, Corps of Engineers. The study was conducted in order to determine the effect of the new program on the economy of the country.

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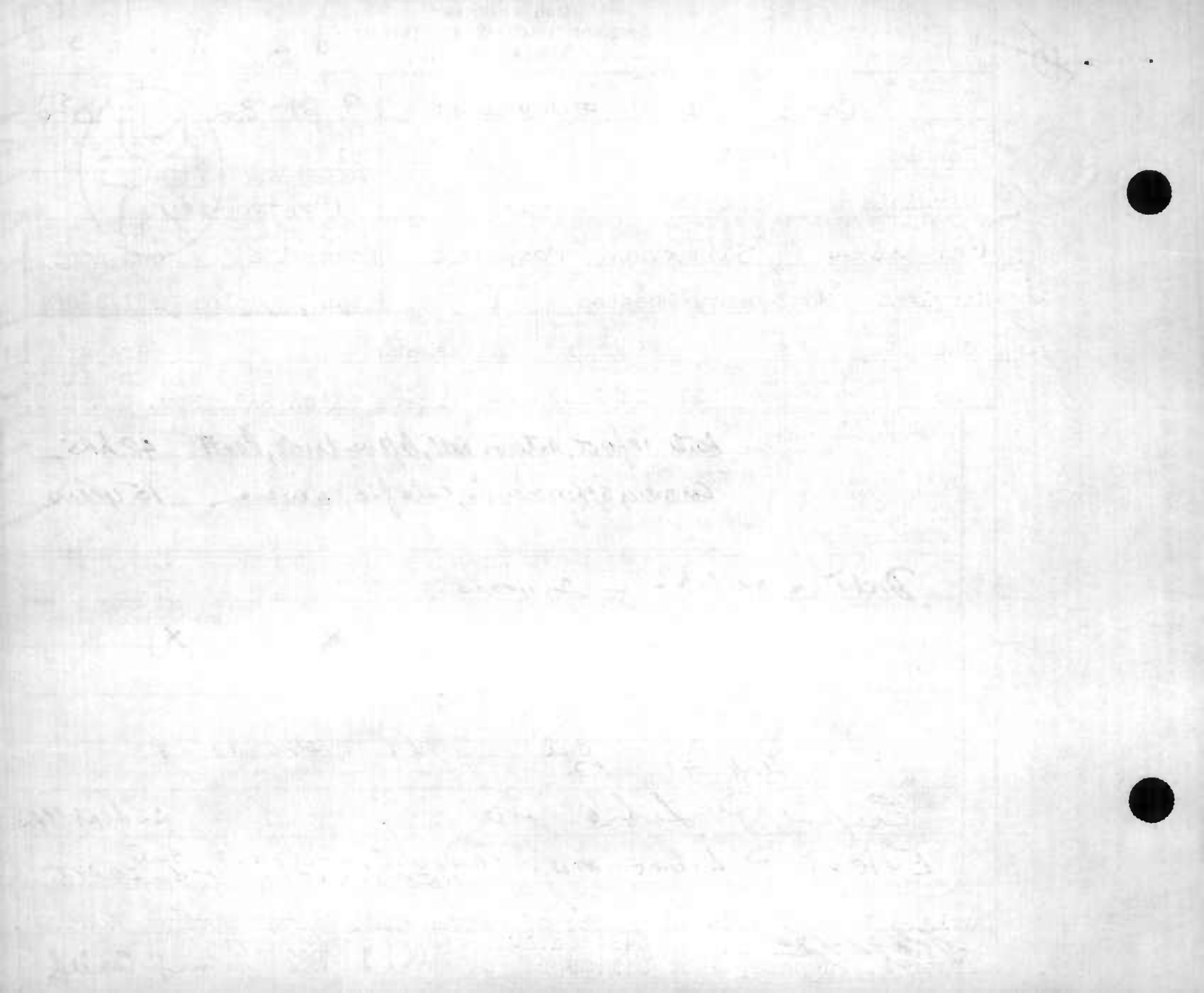
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 6 0 REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Doris L. Underwood | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-21-82 | | 2b. HOUR 10:54 P.M. | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 3 25 21 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 61 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? America | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Wheaton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 4506 Randolph Rd. (20906) | | 14. FATHER'S NAME FIRST MIDDLE LAST Otto A Fischer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Gregory | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 578 22 3150 | | 17. INFORMANT ADDRESS 9407 Pin Oak Drive Mrs. George Allen Sil. Spr. Md. 20910 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute infarct, anterior wall, left ventricle, heart DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis, calcific, averse DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 15 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bilateral nephritis - 20 years | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 21 1982 to Nov 21 1982 , that (I) (we) lost saw the deceased alive on Oct 21 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Eugene P. Libre MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 22 Sept 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE MD | | 22e. ADDRESS 10460 CONNECTICUT AVE KENSINGTON MD. 20885 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont. Md. | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey Inc. | | 8434 Ga. AVE SIL. SPR. MD. | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canich | |

BP



BH

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

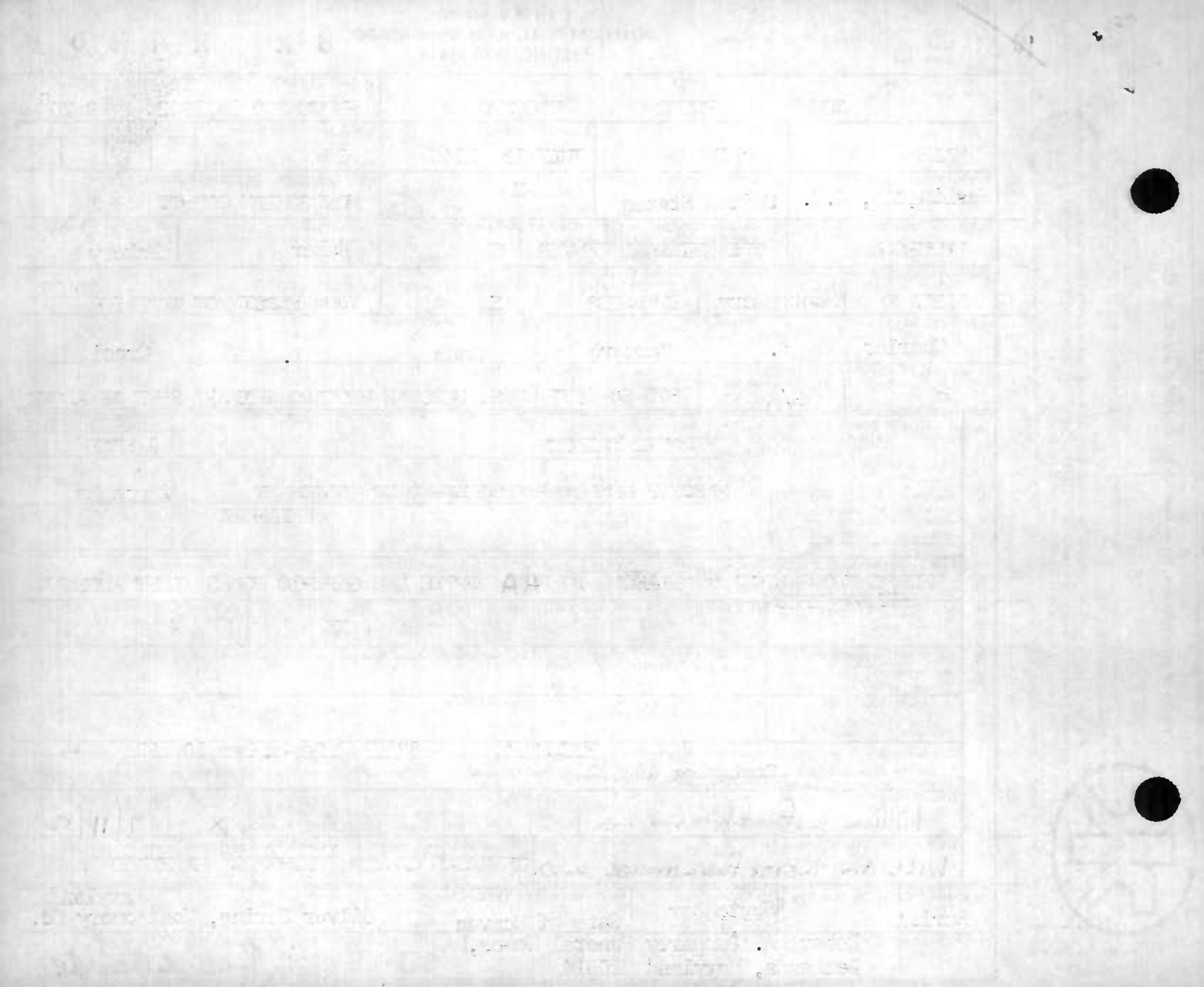
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 4 2 6 1
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN PETER VACCARO | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 10, 1982 | | 2b. HOUR 8:20 ^a M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JULY 15, 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | 12b. KIND OF BUSINESS OR INDUSTRY Bakery | |
| 13a. STATE MARYLAND | 13b. COUNTY Montgomery | 13c. CITY OR TOWN BETHESDA | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 7004 PERSIMMON TREE RD 20817 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Vaccaro | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna I. Croci | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A | | 16b. SOCIAL SECURITY NO. 578-60-4977 | | 17. INFORMANT ADDRESS MRS. DEBORAH VACCARO (WIFE) SAME AS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 1729 DUE TO, OR AS A CONSEQUENCE OF MASSIVE METASTASES TO LIVER OF MALIGNANT MELANOMA DUE TO, OR AS A CONSEQUENCE OF 2 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) METASTATIC MALIGNANT MELANOMA TO PARA-AORTIC AND GASTRIC NODES, LEFT ADRENAL GLAND, ILEUM | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (s) (this hospital) attended the deceased from AUGUST 4, 19 82, to September 10, 82, that (s) (we) lost saw the deceased alive on September 10, 19 82, and that (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William K. Funkhouser, M.D. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Keith Funkhouser, M.D. | | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE September 14, 1982 | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montgomery Co. Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | ADDRESS Funeral Homes, PA Bethesda, Maryland 20014 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE Sam J. Casper | | | |

BP



Items #13a-13e Film G574 12/2/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 6 2

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Walter Vaslow | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1982 | | | 2b. HOUR 9:00 A.M. | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR July 18, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7205 Orkney Parkway | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker | | 12b. KIND OF BUSINESS OR INDUSTRY Edward Jones | |
| 13a. STATE OF RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b. COUNTY Montgomery | | 13c. CITY Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8112 Stratford Dr. 7205 Orkney Parkway | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Morris Vaslow | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Brova | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Peter Vaslow/Son | | ADDRESS 7205 Orkney Parkway Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (b) GLIOBLASTOMA - MULTIFORME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Prostate Hypertrophy | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 23 Aug 1982 to 13 Sep 1982 , that (we) lost saw the deceased alive on 22 Aug 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Eugene P. Libe | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 13 Sep 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBE MD | | | | 22e. ADDRESS 10400 CONNECTICUT AVE Kensington Md 20795 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE Sept. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences | | 23d. LOCATION COUNTY STATE Bethesda, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Capitol Funeral Service | | | | ADDRESS Falls Church, Va. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 business days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The following information is being provided for your information:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Mae Vickrey | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/18/82 | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 5 1895 | | 2b. HOUR 9¹⁰ P^M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Chevy Chase | | 13d. STREET ADDRESS 5100 Dorset Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Rummel | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Sargeant | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 213-16-2868 | | 17. INFORMANT ADDRESS Barbara Fisk. 720 Meadow Lane, Chevy Chase Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO OR AS A CONSEQUENCE OF (b) Acute Massive Posterior Myocardial Infarct DUE TO OR AS A CONSEQUENCE OF (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 7 hours several years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Partial Small Bowel Obstruction | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Sept 19 72 | | | | | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE Sept 19 72 | | | | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 72 to 9/18/82 and that (I) last opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | |
| 22b. SIGNATURE Michel M. Healy MD | | | | | 22c. DATE SIGNED 9/19/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michel M. HEALY, MD | | | | | 22e. ADDRESS 5652 Shields Dr Bethesda MD 20817 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 9/21/1982 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1982 | | | | | |
| 25b. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C. | | | | | 25c. REGISTRAR'S SIGNATURE John J. Smith | | | | | |

BP



Missouri

Nov. 5 1895

Missouri

Montgomery

Montgomery

Barbara Dick. 750 Mendon Lane, Chevy Chase

Missouri

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner in charge.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 6 4 REG. NO. | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES VITALE | | | | 2b. HOUR 0945^{AM} | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 23 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 74 HRS 86 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MAINTAINING LIFE) Shower Ret'd Attendant | | 12b. KIND OF BUSINESS OR INDUSTRY School System | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE Md. | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Woodbine | | 13e. STREET ADDRESS Rt. #1 Box 469 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert G. Snyder | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Virginia McDonald | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 214-22-3834 | | 17. INFORMANT ADDRESS Betty Jane Monaghan Abbottstown, Pa. 17301 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Cancer 1919 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma, Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1975 to date of death 19 82 , that (I) last saw the deceased alive on 9/13/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thos G. WARD M.D. | | | | 22c. ADDRESS 6116 Rockwood, Bethesda 20817 | | 22d. DATE SIGNED 9/13/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md. | |
| 24. FUNERAL DIRECTOR NAME Rosabell Sandison | | | | 25a. DATE REC'D BY REGISTRAR SEP 17 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |
| 26. GARTNER SANDISON F.H. Gaithersburg, Md. 20877 | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 2 6 5 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Andrew Angelo Vizzi | | | | 2b. HOUR 3:50P M | | | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Argentina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | 12a. USUAL OCCUPATION (1) OF DECEASED OR (2) OF DECEASED'S USUAL OCCUPATION Civil Engineer | | 12b. KIND OF BUSINESS OR Firm Corp. Bechtel Corp. | |
| 13a. STATE Md. | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Woodbine | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS Jennings Chapel Rd. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Giovanni - Vizzi | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelica - Licata | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 053-16-8033 | | 17. INFORMANT ADDRESS Darius A. Vizzi Glendale, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Fibrosarcoma.</i> 1739 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Hypoxemia 2° Bilateral lung metastasis. Congestive heart failure. Aortic stenosis.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 15</i> , 19 <i>82</i> , to <i>Sept 3</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>3 Sept</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) <i>examine</i> the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Donald E. Dillon MD</i> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3 Sept 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M. D. | | | | 22e. ADDRESS 18111 Prince Philip Drive Olney, MD 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 7, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Poplar Springs | | 23d. LOCATION CITY OR TOWN COUNTY STATE Poplar Springs Howard Md. | |
| 24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i> | |

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Jan. 2, 1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, then medical examiner must be notified at once.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| Item 13e per phone 10/6/82 dad | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 2 4 2 6 6 | |
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ANNA VIANGAS | | | | SEPT 30, 1982 | | 5 30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | 1 23 92 | | 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Greece | | U.S.A. | | | | Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Kensington | | Circle Manor Nursing Home | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 123 W. 29th Street 21218 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| Gus Tompkeys | | | | Alex | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 212-18-3552 B | | Stella Vlangas | | 3017 Delmar Avenue Balto, MD 21219 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> | | | | | | | 10 yrs |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) this hospital attended the deceased from 9/30/82 to 9/30/82, that (b) I saw the deceased (a) on above, (c) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | B.A. ROSENBAUM | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 9/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| B.A. ROSENBAUM | | | | 3720 FARRAGUT AVE KENSINGTON, MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 10/4/82 | | Greek Orthodox | | CITY OR TOWN COUNTY STATE | |
| | | | | | | Woodlawn, Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222 | | | | OCT 5 1982 | | John J. Connel | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 6 7 REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|---------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Harriet R Wade | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 27, 1982 | | | | | 2b. HOUR 5:00 P | | | |
| 3. SEX Female | | 4. RACE caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 4 26 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15316 PINE ORCHARD DRIVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS DURING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN MONTGOMERY 13c. STREET ADDRESS SILVER SPRING | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 15316 PINE ORCHARD DR. 20906 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ERNEST T. REAMY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNADINE CORBEY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-1575 | | 17. INFORMANT DAUGHTER | | ADDRESS 7908 RAPHAEL CT. 20854 | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BREAST CARCINOMA WITH WIDESPREAD METASTASES 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 13, 1982 , to SEPT 27, 1982 , that (I) (we) lost saw the deceased alive on SEPT. 21, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Eugene P. Flannery | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 28 SEPT 82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY | | | | | 22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD. 20832 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 Univ. Blvd., W., Silver Spring, Md. 20901 | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VIR A15 ME (5))
15M 7/76

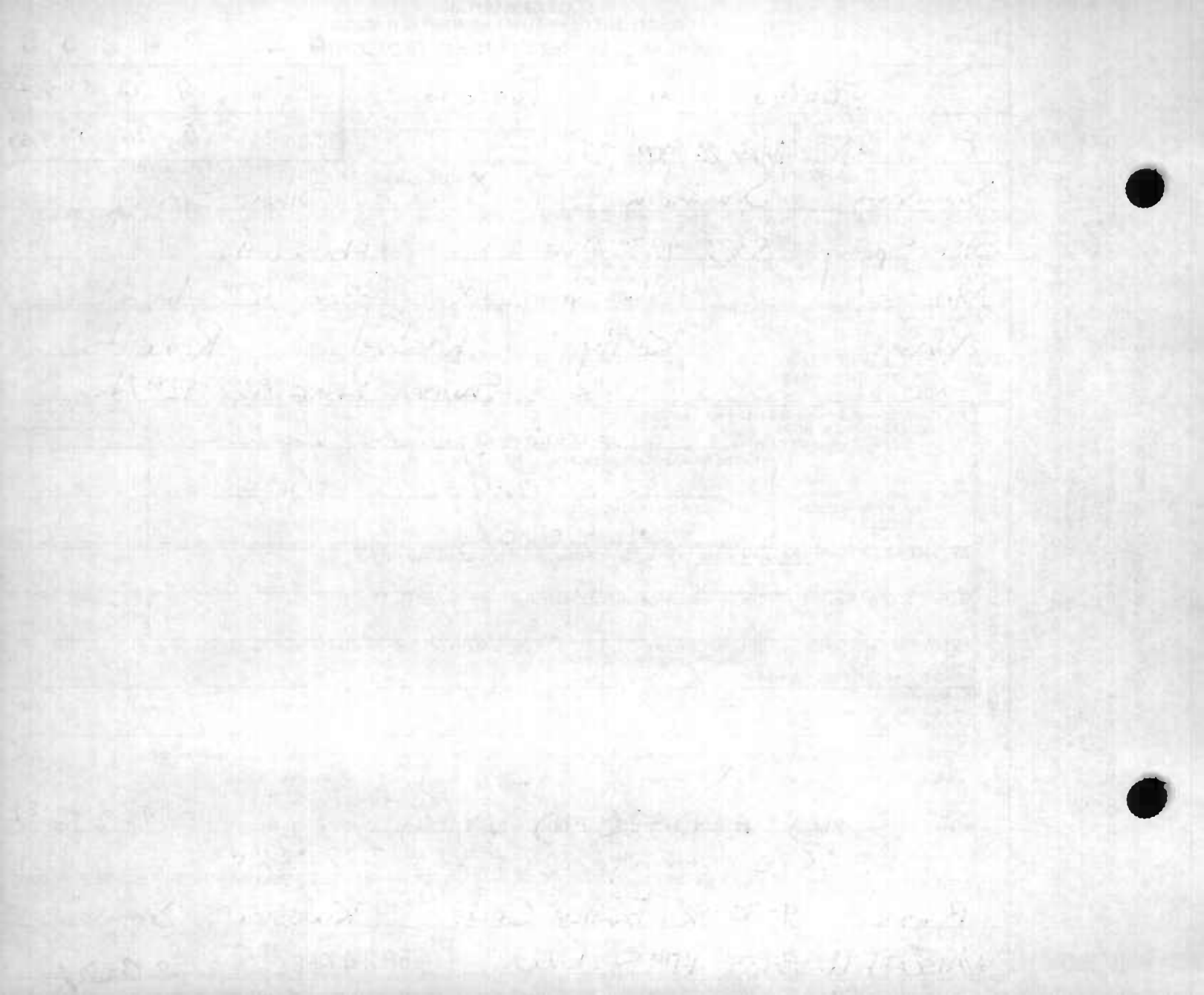
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 4 2 6 8

1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|--|--|--|---|--|---|--|--------------------------------|--|---|--|------------------------|--|--|--|--|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Glady's | | MIDDLE M. | | LAST Waldron | | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH 9 | | DAY 23 | | YEAR 1982 | | 2b. HOUR 9 AM | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR May 26 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | MONTH 9 | | DAY 23 | | YEAR 1982 | | 2d. HOUR 9 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sammacia | | | | 7b. CITIZEN OF WHAT COUNTRY? Sammacia | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Silver Spring MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8322 12 TH AVE. | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD. | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 8322 12 TH AVE. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Adam Kelly | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Roberts | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. UNK | | | | 17. INFORMANT ADDRESS SAUDRA PHANG 8322 12 TH AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hx of advanced carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of ovary</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) SAID A. DARR MD Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 9-23-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS 5632 Annapolis #4 2770220 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (S-E) | | | | 23b. DATE 9-30-82 | | | | 23c. NAME OF CEMETERY OR CREMATORY FAMILY CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE KINGSTON Sammacia | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS WATSON F.H. 3435 14 TH ST. N.W. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1982 | | | | 25b. REGISTRAR'S SIGNATURE J. G. J. Corbett | | | | | | | | | |

MEDICAL CERTIFICATION



Released to Dr. Rosenblum by Dr. Wangel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

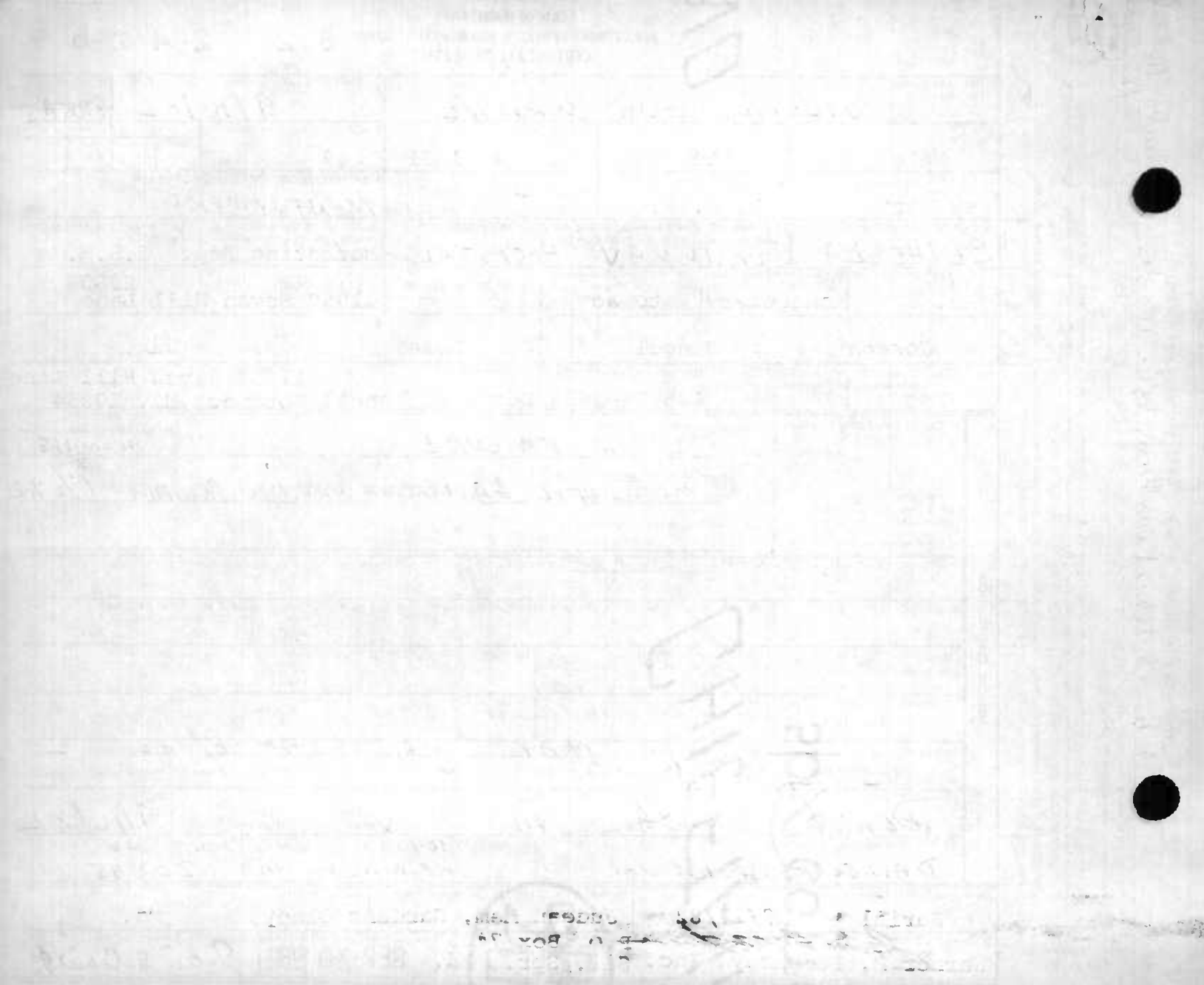
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 6 9

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MIDDLE LAST | | 9 16 82 | | 8:05 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | White | | MONTH DAY YEAR | |
| | | | | 12 4 1931 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| New York | | U. S. A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BETHESDA | | SUBURBAN HOSPITAL | | MONTGOMERY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Marketing Rep. | | I.B.M. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | Montgomery | | Potomac | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Joseph Wangel | | Rose Unk. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | | 105-24-2653 | | 11058 Seven Hill Lane | |
| | | | | Norma J. Wangel Potomac, Md. 20854 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) LIVER FAILURE | | | | | MONTHS |
| 1991 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| (b) METASTATIC CARCINOMA, UNKNOWN PRIMARY | | | | | 1 1/2 YRS |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 19 81 to SEPT 16 19 82, that (I) (we) last saw the deceased alive on SEPT 16 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Daniel Rosenblum | | MD | | 9/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DANIEL ROSENBLUM | | 10400 CONNECTICUT AV KENSINGTON, MD 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/17/82 | | Judean Mem. Gardens Olney, Md. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. NAME OF CEMETERY OR CREMATORY | | 23f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 24. FUNERAL DIRECTOR | | P.O. Box 7428 | | 25a. DATE REC'D. BY REGISTRAR | |
| Warner E. Pumphrey, Inc. | | Sil. Spr., Md. | | SEP 20 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | John J. Conner | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 4 2 7 0

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nelson Commodore Ware | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-27-82 | | 2b. HOUR 6:20 PM |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH Kensington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | 13b. COUNTY Montg. | 13c. CITY OR TOWN Wheaton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 12036 Valleywood Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Tom WARE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 577-12-8218 | | 17. INFORMANT ADDRESS Thomas Ware (son) same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardio-vascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27 1982 to 9/27 1982 , that (I) (we) last saw the deceased alive on 9/27 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B.N. ROSENBAUM, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSENBAUM | | 22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD. 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 9-30-82 | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | ADDRESS 246 N. Wash. St. Rockville, MD. | | 25a. DATE RECEIVED BY REGISTRAR SEP 29 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE John J. Cairns | | | |

MEDICAL CERTIFICATION

13813 10111 1000

RECEIVED
JAN 12 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
20250

OFFICE OF THE DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.
20535

REPORT OF THE DIRECTOR
JAN 12 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Checked by Doctor - Dr. John Rogers

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 8 2 | | 2 4 2 7 1 | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DR. ARTHUR H. WEBB | | 2a. DATE OF DEATH MONTH DAY YEAR 9-23-82 | | 2b. HOUR 11 04 | | 3. SEX MALE | | 4. RACE NEGRO | |
| 5. DATE OF BIRTH MONTH DAY YEAR DEC. 28, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., D. C. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROFESSOR (PhD) | | 12b. KIND OF BUSINESS OR INDUSTRY UNIV.-D. C. | | 13. CITY OR TOWN OF DEATH SILVER SPRING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADDRESSING) 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPR. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1005 LaGrande Rd. | |
| 14. FATHER'S NAME (TYPE OR PRINT) CHARLES LOUIS WEBB | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) GERTRUDE I. HARPER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 354101965 | | 17. INFORMANT Dorothy G. Webb-Wife Silver Spr., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF: (b) idiopathic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF: (c) Metastatic squamous cell carcinoma PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 21b. INJURY OCCURRED | | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1; (DEPARTS)) | | 21e. LOCATION (CITY OR TOWN, COUNTY, STATE) | | 21f. I certify that (I) (this hospital) attended the deceased from Sept. 14 19 82 to Sept. 24 19 82 that (I) (we) last saw the deceased alive on Sept. 23 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| 22a. SIGNATURE <i>Phillip W. Poth, MD</i> | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip W. Poth, MD | | 22c. ADDRESS Suite 240 818 18th Street N.W. Washington D.C. 20006 | | 22d. DATE SIGNED 9/24/82 | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematorium | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) WASHINGTON, D. C. | | 24. FUNERAL DIRECTOR Morrow & Woodford, Inc. 1622 11th. St. NW Wash., D.C. | |
| 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | | SEP 27 1982 | | | | | |

BP



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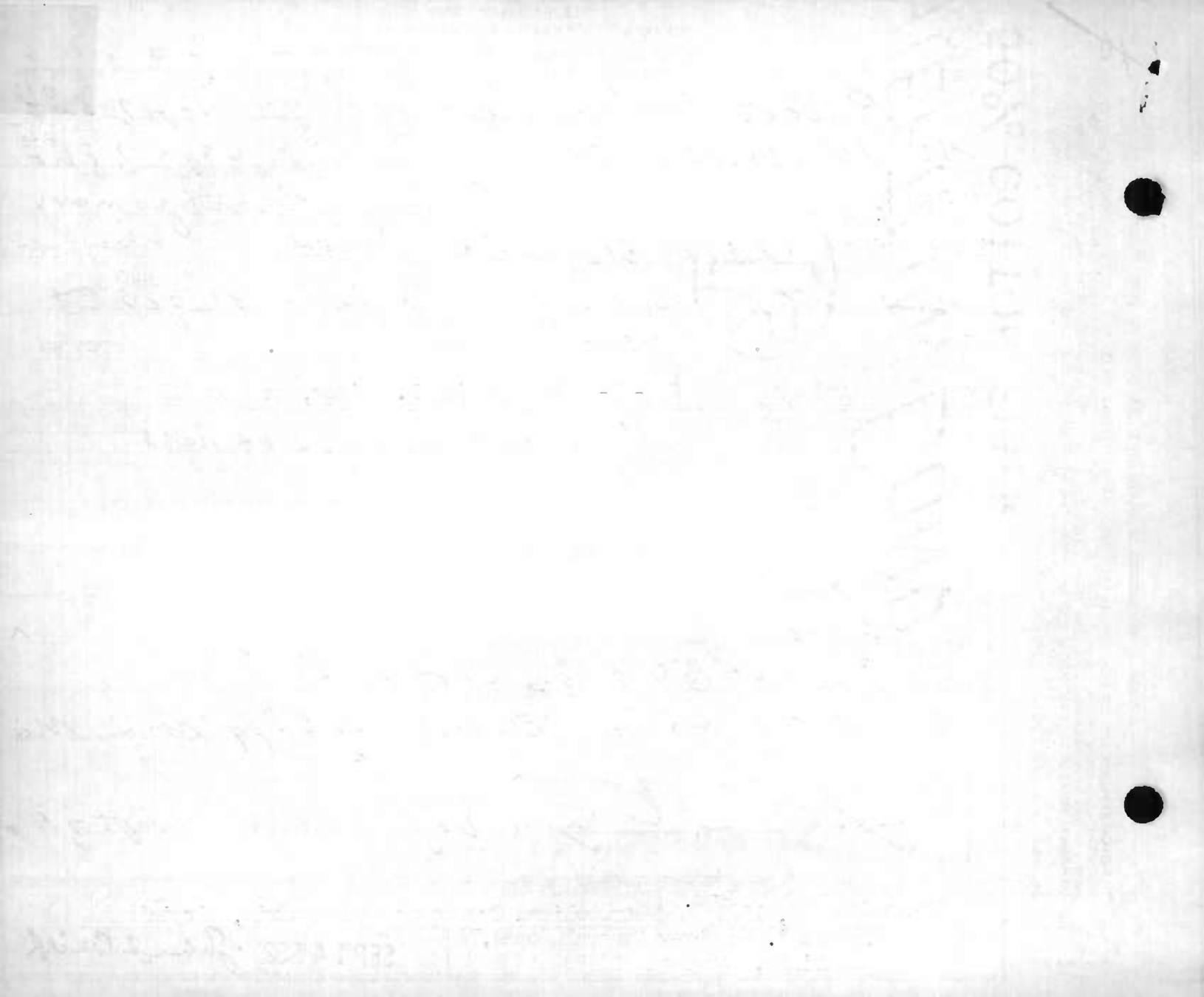


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH INSTRUCTIONS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 24272 |
|--|------------------|---|--|---|---|---|---|--|--|----------------|
| 1. DECEASED NAME (TYPE OR PRINT) Robert William Waiger | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR Sept 7 1982 | | 2b. HOUR 8:30 PM | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR Nov 25 27 54 | 6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept 7 1982 | 2d. HOUR 8:30 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2816 Blazer Ct | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician | | 12b. KIND OF BUSINESS OR INDUSTRY Public Health | | | |
| 13a. STATE MD | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2816 Blazer Ct | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Weiger | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen M. Corcoran | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 306-22-3442 | | 17. INFORMANT ADDRESS Nadine L. Weiger, same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Guns hot wound of head 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> For | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:00 P.M. 9 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Blazer Ct Silver Spring Montgomery Md | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | TITLE (SPECIFY) MD Deps | | MEDICAL EXAMINER | | DATE Sept 7 1982 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Humphrey | | ADDRESS Funeral Homes, PA Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 4 2 7 3

| | | | | | | | | | | | |
|---|---------|--|-------------------|--|---------------------|--|--|---------------------------------------|--|------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | James | | Wilson | | 9/26/ | | 1982 | | 1:21 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | | 10. MONTH | | 11. DAY | |
| male | black | Oct 31 18 | 63 YRS. | | | 9/26/82 | | 1:21 | | | |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 13. CITIZEN OF WHAT COUNTRY? | | 14. MARRIED | | 15. NEVER MARRIED | | 16. BALTIMORE CITY OR COUNTY OF DEATH | | 17. MONTGOMERY COUNTY | |
| Md. | | U.S.A. | | WIDOWED | | DIVORCED | | | | | |
| 18. CITY OR TOWN OF DEATH | | 19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 21. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban Hospital | | LABORER | | | | | | | |
| 22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 23. STATE | | 24. COUNTY | | 25. CITY OR TOWN | | 26. INSIDE CITY LIMITS? | | 27. STREET ADDRESS | |
| Md | | Mont | | Rockville | | YES | | NO | | 7524 Scotland Dr | |
| 28. FATHER'S NAME | | 29. MOTHER'S MAIDEN NAME | | 30. FATHER'S FIRST | | 31. MOTHER'S FIRST | | 32. FATHER'S MIDDLE | | 33. MOTHER'S MIDDLE | |
| William | | Fannie | | Richardson | | Richardson | | Richardson | | Richardson | |
| 34. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 35. SOCIAL SECURITY NO. | | 36. INFORMANT | | 37. ADDRESS | | 38. SAME | | 39. AS #13 | |
| NO | | 212-24-4152 | | Joseph Wilson (Brother) | | same | | same | | same | |
| 40. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 41. PART I DEATH WAS CAUSED BY: | | 42. IMMEDIATE CAUSE (a) | | 43. DUE TO, OR AS A CONSEQUENCE OF | | 44. (b) | | 45. DUE TO, OR AS A CONSEQUENCE OF | |
| 4291 | | Acute Myocardial Dis | | | | | | | | | |
| 46. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LOST. | | 47. (c) | | | | | | | | | |
| 48. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | None | | | | | | | | | |
| 49. DATE OF OPERATION | | 50. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 51. AUTOPSY? | | YES | | NO | | NO | |
| None | | | | | | | | | | | |
| 52. EXTERNAL CAUSE WAS | | 53. TIME OF INJURY | | 54. HOW INJURY OCCURRED | | 55. (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 56. LOCATION | | 57. CITY OR TOWN | |
| UNDERLYING | | HOUR A.M. MONTH DAY YEAR | | | | | | STREET | | COUNTY | |
| OR CONTRIBUTING | | P.M. 19 | | | | | | | | STATE | |
| 58. INJURY OCCURRED | | 59. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 60. WHILE AT WORK | | 61. NOT WHILE AT WORK | | | | | |
| WHILE AT WORK | | | | | | | | | | | |
| 62. I certify that I took charge of the remains described above, held an Autopsy | | 63. Inspection | | 64. Inquiry | | 65. and in my opinion | | 66. death resulted from: | | 67. Natural causes | |
| | | | | | | | | 68. Accident | | 69. Suicide | |
| | | | | | | | | 70. Homicide | | 71. Undetermined manner | |
| 72. ACTUAL SIGNATURE | | 73. TITLE (SPECIFY) | | 74. MEDICAL EXAMINER | | 75. DATE SIGNED | | 76. SEP 26 1982 | | 77. SIGNATURE | |
| 78. EXAMINER'S NAME (TYPE OR PRINT) | | 79. ADDRESS | | | | | | | | | |
| 80. BURIAL, CREMATION, REMOVAL | | 81. DATE | | 82. NAME OF CEMETERY OR CREMATORY | | 83. LOCATION | | 84. CITY OR TOWN | | 85. COUNTY | |
| Burial | | 9-30-82 | | Lincoln Park Cem. | | Rockville | | Montg | | Md. | |
| 86. FUNERAL DIRECTOR | | 87. NAME | | 88. ADDRESS | | 89. DATE REC'D. BY REGISTRAR | | 90. REGISTRAR'S SIGNATURE | | 91. SIGNATURE | |
| George R. Snowden | | 246 N. WASH. | | Rockville, Md | | SEP 29 1982 | | John J. Canine | | | |

2007 OCT 10 11:00 AM

THE FIDELITY UNION



[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]

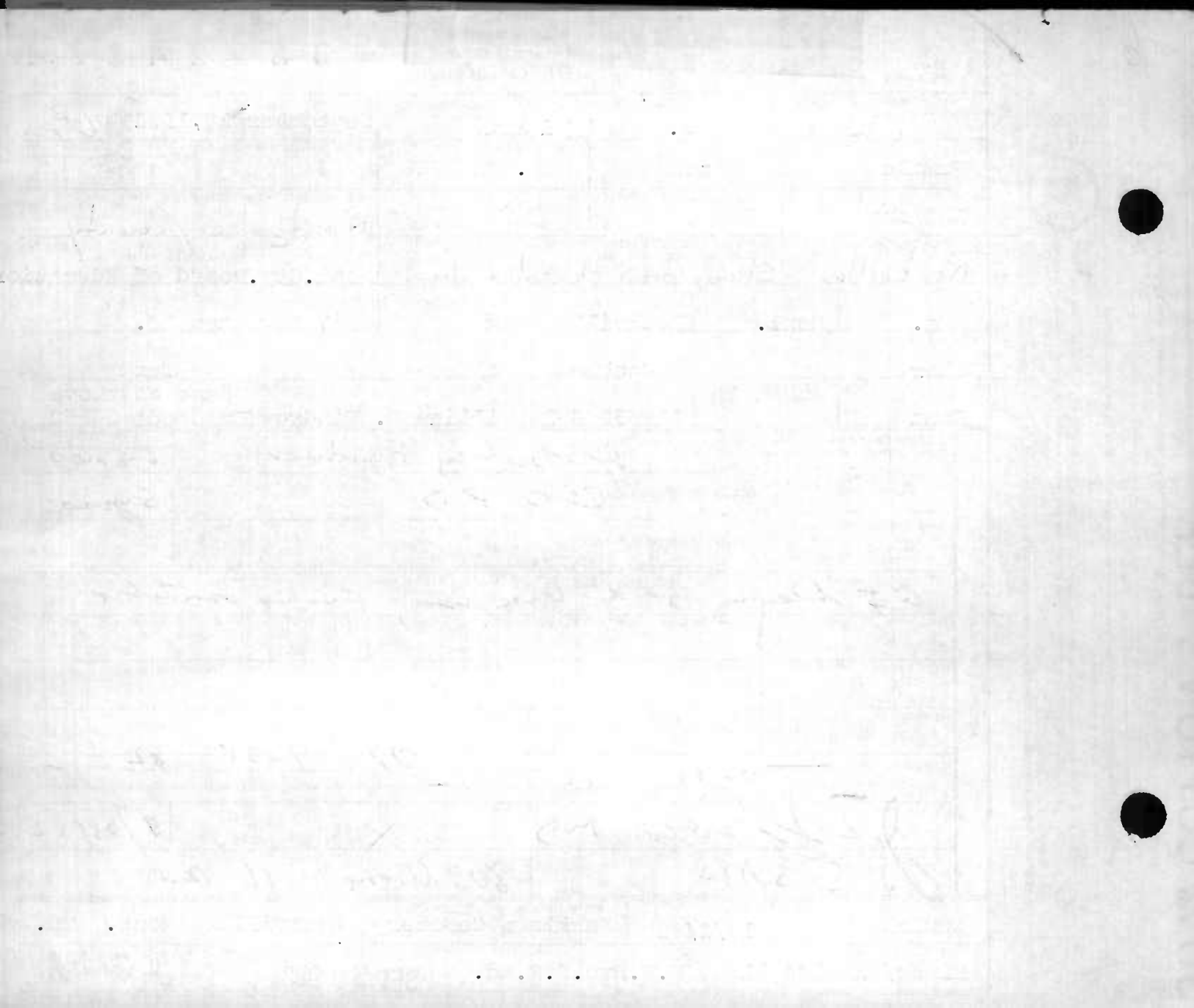
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 2 7 4 | | |
|---|--|--|--|--|--------|---|--------------------|------------------------------|-------|------------------------|------|-----------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| | | Jane H. Windrow | | | | | September 28, 1982 | | | | | 6:15 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | Black | | Feb. 22 1928 | | 54 | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Indiana | | USA | | | | Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Rockville | | Shady Grove Adventist Hosp. | | Mont. Cty. Board of Education | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Md. | | Mont. | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 907 Leverton Rd. | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| Robert | | Alice Turk | | None | | 380 30 6528 | | William D. Windrow (Husband) | | 20852 | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 4960 | | Respiratory Failure | | CO PD | | 6-8 mos | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | 5 yrs | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | GI Bleeding 2° to ulcer disease Fracture vertebrae | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-28-82 to 9-28-82, that (I) (we) last saw the deceased alive on 9-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | |
| | | J. S. SAIA MD | | | | 8/28/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | |
| J. S. SAIA | | 809 Urens M. II Rd | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | |
| Burial | | 10/2/82 | | Parklawn Cemetery | | Rockville Mont. Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Hines/Rinaldi 11800 N.H.Ave.S.S.Md. | | SEP 30 1982 | | John J. Connel | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify the registrar of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 7 5 REG. NO. | | | | |
|--|--|--|--|--|--|---|--|-------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Melvin WINSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-23-82 | | | | 2b. HOUR 2:30 AM |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 15 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMIN. JUDGE ICC | | 12b. KIND OF BUSINESS OR INDUSTRY JUDICIAL | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MOISHE WEINSTEIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FEIDEL RZESTIKOVSKI | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216-44-4499 | | 17. INFORMANT Maryland 20906 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23/82 to 9/23/82 , that (I) (we) last saw the deceased alive on 9/23/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE H.D. Khawar DEGREE MD | | | | 22c. DATE SIGNED 9/23/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.D. KHAWAR | | |
| 22e. ADDRESS Suburban, Bethesda Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 24, 82 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GDN.; FALLS CHURCH; FAIRFAX; VA. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR'S NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1982 | | | | |
| 1170 Rockville Pike; Rockville, Maryland 20852 | | | | 25b. REGISTRAR'S SIGNATURE John J. Carter | | | | |

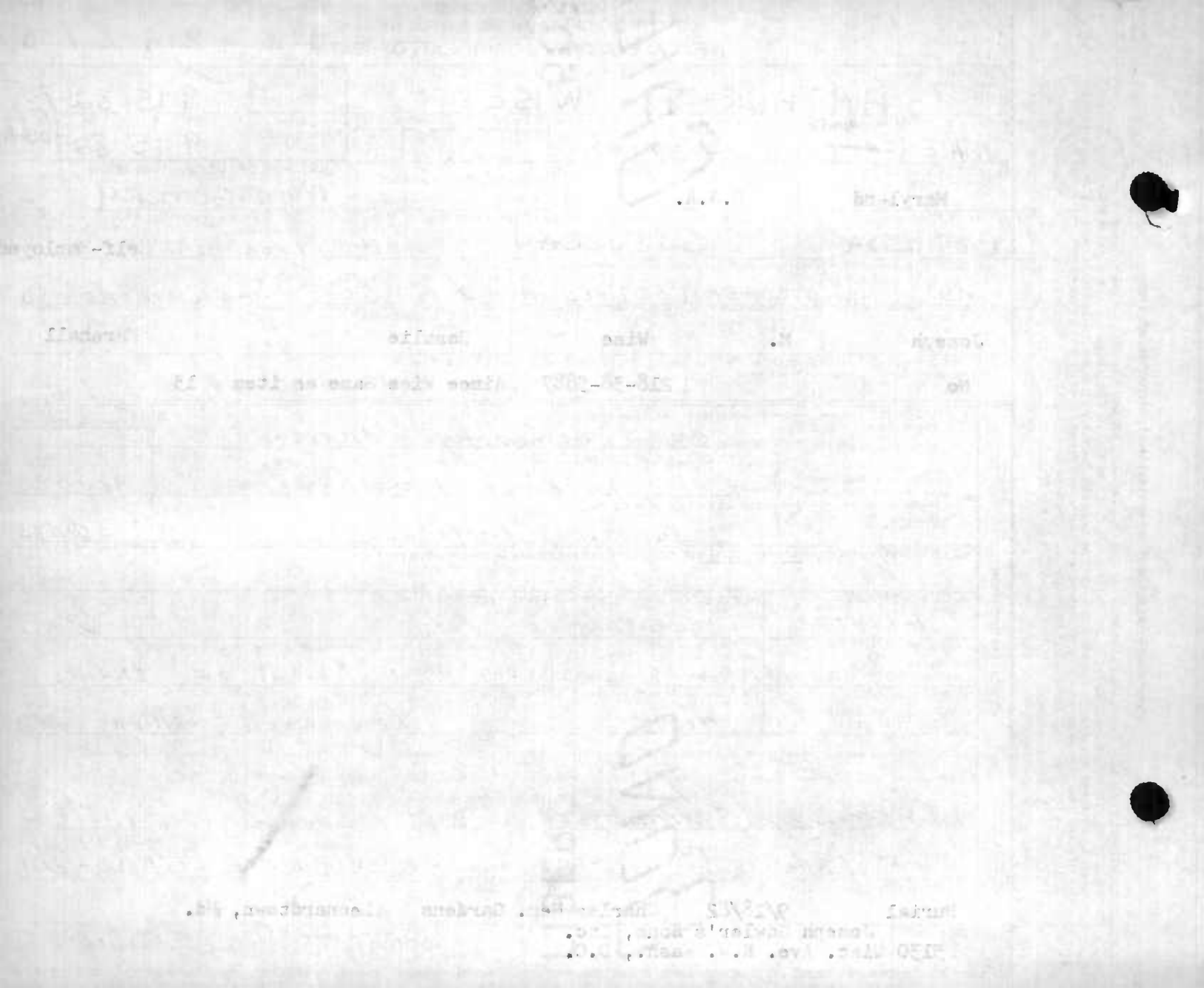
BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN FOUR HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 4 2 7 6 | | | |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|------------------------------|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR T. WISE | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 15 82 | | | | | | | | | | 2b. HOUR M 7:05 | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 24 39 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | IF UNDER 1 YR. MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN. 0 0 | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 15 82 | | | | | | | | | | 2d. HOUR M 10:54 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSIOTHERAPIST | | | | 12b. KIND OF BUSINESS OR INDUSTRY Self-Employed | | | | | | | |
| 13a. STATE MD | | | | | | | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5018 SANGAMORE RD | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph M. Wise | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Marshall | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 218-38-5887 | | | | | 17. INFORMANT ADDRESS Aimee Wise Same as item # 13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE FRACTURES | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 30 DAYS | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9-12-82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? LACERATION OF FOOT | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 0030 9 12 1982 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0030 9 12 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL DOWN FLIGHT OF STAIRS | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | | | 21f. LOCATION STREET LEONARDTOWN | | | | CITY OR TOWN ST MARY | | COUNTY MD | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Francis C Mayle | | | | TITLE (SPECIFY) DEPT | | | | MEDICAL EXAMINER 8200 Wisconsin Ave | | | | DATE SIGNED 9/15/82 20814 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle | | | | ADDRESS BETHESDA MD | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Charles Mem. Gardens | | | | 23d. LOCATION CITY OR TOWN Leonardtown, Md. | | | | COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 7 1 | |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) LOUIS V. WITCHIE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-15-82 | | 2b. HOUR 5:45 P.M. | | | |
| 3. SEX male | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3 4 88 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT GAO | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN WHEATON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11306 GALT AVENUE 20902 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILHELM WITCHIE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY CONROY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW I | | 16b. SOCIAL SECURITY NO. 472-14-8877 | | 17. INFORMANT ADDRESS ALLAN J. WITCHIE SAME AS 13 SON | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5070 (b) possibly aspirated pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/7/82 9/7/82 | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979 , 19 9/15/82 , to 9/15/82 , 19 — , that (I) (we) last saw the deceased alive on 9/15/82 , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  DR. OSOTH LEKAGUL | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. OSOTH LEKAGUL | | 22e. ADDRESS 7425 arlington Rd. Bethesda Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 2 4 2 7 8 | |
|--|--|-------------------------|--|---|--|---|--|---|-------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gloria Jean Wolfe | | | | | | | | | | 2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 9 9 82 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1955 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 26 | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 9 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8400 Old Georgetown Rd -park | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P. F. C. | | 12b. KIND OF BUSINESS OR INDUSTRY U. S. Army | |
| 13a. STATE Indiana | | | | 13b. COUNTY Morgan Co. | | 13c. CITY OR TOWN Martinsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 890 E. Columbus Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard James Wolfe | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Lou (Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Active Duty | | 17. INFORMANT ADDRESS Howard J. Wolfe (Father) Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination from incised wound of neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 9:00 9/9 1982 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:00 9/9 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found with incised wounds | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Greenich Park | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8400 Old Georgetown Rd, Bethesda, Montgomery Co. MD | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H. Guard</i> | | | | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 9/10/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY New S. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Martinsville, Morgan, Indiana | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1982 | | | | | |

MEDICAL CERTIFICATION



10-20-1919

10-20-1919

10-20-1919

10-20-1919



10-20-1919

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|------------------------------------|--|---|--|--|--|--------------------------|--|----------------|--------------------------------------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 2 2 4 2 7 9 | | | | | | |
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 7a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 12:40 P. M. | | |
| Nina W. Wondrack | | | | | | | | | | <input checked="" type="checkbox"/> 9/21 | | 19 82 | | 12:40 P. M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | |
| Female | | White | | Sep. 6, 1897 | | 85 YRS. | | | | | | 9/21 | | 19 82 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| W. Va. | | | | | USA | | | | | | | | | | Montgomery County | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | | | Carriage Hill Nursing Home | | | | | Housewife | | | | | None | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. INSIDE CITY LIMITS? | | 13a. STREET ADDRESS | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6309 Kenhowe Drive | | | | |
| Maryland Montgomery Bethesda | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | ADDRESS | | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | |
| no | | | | | 578-62-1158 | | | | | Daughter - Carol W. Wyman - Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | 22 days | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary embolus | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| (b) fracture of left hip. | | | | | | | | | | 22 days | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | |
| 8/31/82 | | | | Fracture of left hip | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | |
| | | | | P.M. 8/30 1982 | | | | Fell at home | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | |
| | | | | Home | | | | Kenhowe Drive, Bethesda, Montgomery, Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | |
| John S. Rogers, M.D. | | | | Deputy | | | | 9/22/82 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | |
| John S. Rogers, M.D. | | | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | |
| Burial | | | | Sept. 24, 82 | | Ft. Lincoln Cemetery | | | | Washington, D.C. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| James P. Ruff | | | | SEP 29 1982 | | | | J. L. Carter | | | | | | | | |
| FURNERAL HOME | | | | ADDRESS | | | | | | | | | | | | |
| DeVoll Funeral Home | | | | Washington, D.C. | | | | | | | | | | | | |

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 50M 1/81
(VRA 15, 4)

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 4 2 8 0
REG. NO.

| | | | | | | | |
|---|--|---|---|---|-------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RACHAEL S Wood | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 13 82 | | 2b. HOUR 9:35^A | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 90 | | 6. AGE (IN YEARS/LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN MARYLAND MONTGOMERY ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5900 HOLLAND ROAD 20851 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM - STEELE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHEA - BATESON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 194-05-2819 | | 17. INFORMANT ADDRESS DONALD S. WOOD (SON) SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5602 Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) Ruptured Abdominal Vessels (c) Voluntarily Segmented Colon | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Coronary Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 8 1982 to SEP 13 1982 , that (I) (most) host saw the deceased alive on SEP 13 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If another died not view the body after death.) | | | | | | | |
| 22b. SIGNATURE Robert J. Thibadeau DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. THIBADEAU | | | | 22e. ADDRESS ROCKVILLE MD. 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE SEPT. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G. CO. MARYLAND | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | | | ADDRESS SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

JEANSON

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called for removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 8 1 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM FENDERSON WOODMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 15 1982 | | 2b. HOUR 4:00 a.m. | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 26 1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 62 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY U. S. Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA | | | | 13b. CITY OR TOWN MCLEAN | | 13c. STREET ADDRESS 1602 LONGFELLOW STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILL WOODMAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY DOLANHAITE DOLLAHITE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1937-1959 | | 17. INFORMANT ADDRESS DOROTHY WOODMAN, 1602 LONGFELLOW STREET | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Spurs DUE TO, OR AS A CONSEQUENCE OF (b) unspread metastatic adenocarcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 31 , 19 82 , to SEPTEMBER 15 , 19 82 , that (I) (we) lost saw the deceased alive on SEPTEMBER 15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (in) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DENNIS L. AZUMA | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS L. AZUMA, LT, MC, USNR | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | |
| 24. FUNERAL DIRECTOR NAME Money & King Funeral Home | | | | 25a. DATE RECEIVED BY REGISTRAR SEP 23 1982 | | | |
| 171 W. Maple Ave., Vienna, Va. 22180 | | | | | | | |

U.S. COTTON



See you soon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 4 2 8 2 | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN V. WURDEMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09/13/82 | | | |
| 3. SEX MALE | | | | 2b. HOUR 1745 M | | | |
| 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 2, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINOTYPETER | | 12b. KIND OF BUSINESS OR INDUSTRY WASH. POST | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK WURDEMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANIE SMITH | | 13e. STREET ADDRESS 8801 HONEYBEE LANE 20817 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 223-14-0914 | | 17. INFORMANT ADDRESS LEIRA H. WURDEMAN SAME AS 13 WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 8 years 8 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Carcinoma of the bladder | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 13, 1982 , to Sept 13, 1982 , that (I) (we) lost saw the deceased alive on Sept 13, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Heath Let | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN GRAP | | 22e. ADDRESS 13-15 E. DEER PARK DRIVE | | CATHERSBURG MD 20717 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | 24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 17 1982 | | | |

BP _____

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 8 3 REG. NO. | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) CYRIL HAMILTON YORK | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 13 82 | | | | 2b. HOUR 12:45 AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOK BINDER | | 12b. KIND OF BUSINESS OR INDUSTRY G.P.O. | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 503 GREENBRIER DRIVE | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EBEN R. YORK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELLA HAMILTON | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT CATHERINE C. YORK | | ADDRESS SAME AS 13 | | WIFE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Thrombocytopenia Probably Subleukemic hemophilia. Sepsis. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12 , 19 82 , to Sept 13 , 19 82 , that (I) (we) lost saw the deceased alive on Sept 12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Hugo G. Graziani M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-13-82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hugo G. Graziani | | 22e. ADDRESS 717 Rocking N. S.S. Md. 20910 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

MEDICAL CERTIFICATION



1. Name of the plant or animal: *Hydrocotyle*
2. Locality: *W. I.*
3. Date of collection: *1913*
4. Name of collector: *W. H. S. & J. W.*
5. Name of the person to whom the specimen was sent: *W. H. S.*
6. Name of the person who prepared the specimen: *W. H. S.*
7. Name of the person who examined the specimen: *W. H. S.*
8. Name of the person who distributed the specimen: *W. H. S.*
9. Name of the person who received the specimen: *W. H. S.*
10. Name of the person who stored the specimen: *W. H. S.*

11. Name of the person who prepared the specimen: *W. H. S.*
12. Name of the person who examined the specimen: *W. H. S.*
13. Name of the person who distributed the specimen: *W. H. S.*
14. Name of the person who received the specimen: *W. H. S.*
15. Name of the person who stored the specimen: *W. H. S.*

16. Name of the person who prepared the specimen: *W. H. S.*
17. Name of the person who examined the specimen: *W. H. S.*
18. Name of the person who distributed the specimen: *W. H. S.*
19. Name of the person who received the specimen: *W. H. S.*
20. Name of the person who stored the specimen: *W. H. S.*

21. Name of the person who prepared the specimen: *W. H. S.*
22. Name of the person who examined the specimen: *W. H. S.*
23. Name of the person who distributed the specimen: *W. H. S.*
24. Name of the person who received the specimen: *W. H. S.*
25. Name of the person who stored the specimen: *W. H. S.*

26. Name of the person who prepared the specimen: *W. H. S.*
27. Name of the person who examined the specimen: *W. H. S.*
28. Name of the person who distributed the specimen: *W. H. S.*
29. Name of the person who received the specimen: *W. H. S.*
30. Name of the person who stored the specimen: *W. H. S.*

31. Name of the person who prepared the specimen: *W. H. S.*
32. Name of the person who examined the specimen: *W. H. S.*
33. Name of the person who distributed the specimen: *W. H. S.*
34. Name of the person who received the specimen: *W. H. S.*
35. Name of the person who stored the specimen: *W. H. S.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a copy of this certificate will be furnished to the medical examiner.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|--|--|
| 1. STATE REGISTRAR | | REG. NO. 8 2 2 4 2 8 4 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GLADYS H. YOUNG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 6 82 | | | | | 2b. HOUR 9:35 AM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian | | 12b. KIND OF BUSINESS OR INDUSTRY Public Sch. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fred F. Hildreth | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Smith | | | | | 16. STREET ADDRESS 4024 Franklin Street | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Constance Root, Kensington, MD. 20895 | | ADDRESS 4024 Franklin Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal cardiopulmonary arrest</u> 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congestive heart failure, renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8/30/82</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/6/82 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976, 19, to 9/6/82, 19, that (I) (we) lost saw the deceased alive on 9/6/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. OSOTH CERAGUL | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 9/6/82 | |
| 22e. ADDRESS 7425 ARLINGTON RD. BETHESDA, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9-8-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Pearson's Funeral Home, Falls Church, Va. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 8 5 REG. NO. | | | | |
|--|--|---|--|---|--|--|--|---------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) ETANORA M. YOUNG BLOOD | | | | 2a. DATE OF DEATH MONTH 9 DAY 8 YEAR 82 | | | | 2b. HOUR 9:45 M |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH APRIL DAY 16 YEAR 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK-ACCIDENT INSURANCE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST JESSE MIDDLE JAMES LAST MARVEL | | 15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE ELIZABETH LAST ELIZABETH | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | |
| 16a. SOCIAL SECURITY NO. 578-40-1466 | | 17. INFORMANT ADDRESS CHARLES H. YOUNG BLOOD, ARLINGTON, VA. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of colon with wide metastases 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 85 , to 9/18 , 19 85 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 9/18 , 19 85 , and that (I) <input checked="" type="checkbox"/> (and) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Alan Weissfeld | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/18/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Weissfeld | | 22e. ADDRESS 1295 Cambridge Dr Silver Spring | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/11/1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Washington | | 23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Maryland | | |
| 24. FUNERAL DIRECTOR NSA Capital ST. Paul's Wash. DC | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 8 0 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ROSE ZESERMAN</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-30-82</i> | | | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 10, 1896</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>86</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD. | |
| 10 CITY OR TOWN OF DEATH <i>ROCKVILLE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home of Greater Washington</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Rockville</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Melnicov</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frieda Kazminsky</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>578-62-3916</i> | | 17. INFORMANT <i>Rockville, Md. 20852 Helen Baker; 12027 Whippoorwill Lane;</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease.</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus, severe senile dementia.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>7-1</i> 19 <i>81</i> , to <i>9-30</i> 19 <i>82</i> , that (I) (have) lost saw the deceased alive on <i>9/29</i> 19 <i>82</i> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (have) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>K Shah MD</i> | | | | DEGREE | | 22c. DATE SIGNED <i>9/30/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K. H. SHAH</i> | | | | 22e. ADDRESS <i>6105 Montrose Road, Rockville, MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>10/1/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. GARDEN</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH; FAIRFAX, VA.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 5 1982</i> | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | 25b. REGISTRAR'S SIGNATURE <i>James J. Conner</i> | | | |

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

Report of the
Commissioner of Plant Industry
for the year ending June 30, 1911

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PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 4 2 8 7 REG. NO. | | | |
|--|--|--|--|---|---|---|--|--|--|-------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EVELEEN (NMN) ZOMBRO | | | | | 2a. DATE OF DEATH SEPTEMBER 11, 1982 | | | | | 2b. HOUR 10:15pm | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH OCTOBER 16, 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER, NIH, BETHESDA, MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) At Home | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | | | | | |
| 13a. STATE VIRGINIA | | 13b. COUNTY Prince William | | 13c. CITY OR TOWN WOODBIDGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1602 RIDGE ROAD | | 22192 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Strother Barron | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Manuel | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 235-50-3940 | | 17. INFORMANT ADDRESS Mr. Melvin Zombro, husband, same as patient | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, severe</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic ovarian carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>2 1/2 years</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 16</u> , 19 <u>82</u> , to <u>SEPTEMBER 11</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPTEMBER 11</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>C.A. Harmon</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/12/82</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C.A. Harmon</u> | | | | | | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Edgehill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Charlestown, West Virginia | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>Sara M. Brown</u> <u>13318 Occoquan Rd. Woodbridge, VA</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 16 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

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U. S. A. 1934

James William

James William

1934-10-10

James William

James William

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will need to be notified and a necropsy performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 4 2 8 8 REG. NO. | | | |
|---|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST MIDDLE LAST JOHN JOSEPH ZORNEK | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR September 5, 1982 2 05 PM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DAY OF BIRTH MONTH DAY YEAR NOV. 14, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEGRAPHER | | 12b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER | |
| 13a. STATE MARYLAND | | 13b. COUNTY HOWARD Co. | | 13c. CITY OR TOWN COLUMBIA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 5476 TILTED STONE | | 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH P. ZORNEK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE E. METZLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 718-14-9877 | | 17. INFORMANT ADDRESS VIRGINIA L. ZORNEK (WIFE) SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordine respiratory arrest 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metabolic acidosis (c) Carcinoma of the colon with metastases | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours 7 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Asbestos - Probably squamous | | | | | | | |
| 19a. DATE OF OPERATION 9/5/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 69 to Sept 5 19 82 , that (I) (we) saw the deceased alive on Sept 5 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hugo G. Graziani | | | | DEGREE MD | | 22c. DATE SIGNED 9-5-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGO G GRAZIANI | | | | 22e. ADDRESS 717 Pershing Dr Silver Spring, Md. 20910. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE SEPT. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G. Co. MARYLAND | |
| 24. FUNERAL DIRECTOR, NAME CHAMBERS FUNERAL HOME RIVERDALE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | |

BP.

1944 - 1945 - 1946

MALF WHITE

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